You have received this "Request for Applications (RFA)" through USAID Internet site. If you have any questions regarding this RFA you may contact the USAID Official named in the cover letter of this solicitation. If you are not using Word 97 to view this document, you will have to save the document in the format of the wordprocessor that you are using in order to view and print any standard forms. The number of pages contained in this electronic copy may not exactly correspond to the hard paper copy, although generally all the information is contained herein.

The Agency is not responsible for any data/text that may not be received when retrieving this document electronically. If the recipient does not notify the contact person that they have obtained this document then any amendments to the document may not be available to the recipients. Amendments to solicitation documents generally contain information critical to the submission of an application.

CAMBODIA 442-02-002

Health Systems Strengthening in Cambodia

Issuance Date: May 31, 2002
Closing Date: July 15, 2002
Closing Time: 16:00pm local Cambodia time

Subject: Request for Applications (RFA) no. 442-02-002 (Cambodia)
Health Systems Strengthening in Cambodia.

The United States Agency for International Development (USAID) is seeking applications for a cooperative agreement from an organization for funding a program for Health Systems Strengthening in Cambodia.. The authority for the RFA is found in the Foreign Assistance Act of 1961, as amended.

The Recipient will be responsible for ensuring achievement of the program objectives in the Cambodian Health Sector. Please refer to the Program Description (RFA section C) for a complete statement of goals and expected results.

Pursuant to 22 CFR 226.81, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to the program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organization, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the agreement.

Subject to the availability of funds, USAID intends to provide approximately $9,000,000.00 (nine million US dollars) in total USAID funding to be allocated over a three-year period. USAID reserves the right to fund any or none of the applications submitted. Although it is planned to make an award of one cooperative agreement, in its discretion USAID may make awards to more than one organization.

For the purposes of this program, this RFA is being issued and consists of this cover letter and the following:

1. Section A - Grant Application Format;
2. Section B - Selection Criteria;
3. Section C - Program Description;
4. Section D - Certifications, Assurances, and Other Statements of Applicant/Re4cipient;
5. Program Attachments for Reference.

For the purposes of this RFA, the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer".

If you decide to submit an application, it should be received by the closing date and time indicated at the top of this cover letter at the place designated below for receipt of applications. Applicants are requested to submit their applications by e-mail attachment (formatted in Microsoft Word), with hard copies to follow (please see section A.1.h of the RFA for detailed instruction regarding submission of applications via email). Applications and modifications thereof shall be submitted with the name and address of the applicant and the RFA # (referenced above) inscribed thereon, to:

Carey N. Gordon at: cagordon@usaid.gov

Applicants shall confirm with the USAID Agreement Officer, Carey N. Gordon, that their e-mail submissions were successfully received by the required due date. Three hard copies of applications shall be sent to:

By Courier:	or	By International Mail:
Carey N. Gordon		Carey N. Gordon
USAID Cambodia, American Embassy		USAID Cambodia, Box P

#18, Street 228 APO AP 96546
Phnom Penh, Cambodia (USA)

Hard copies of submissions need not arrive by the due date, provided that the e-mail submissions have been successfully received by the due date. It is recommended that applicants use courier service instead of international mail for the hard copies. Applications will be accepted for consideration as long as they arrive in Phnom Penh by the time stipulated. See RFA Section A.1.b regarding late applications. If you have questions regarding this RFA, please address them to Mr. Carey N. Gordon, Agreement Officer, USAID/Cambodia (fax: 855-23-217-638 or 855-23-216-437; e-mail address: cagordon@usaid.gov).

Applicants are requested to submit both technical and cost portions of their applications in separate volumes. Award will be made to that responsible applicant(s) whose application(s) best meets the requirements of this RFA and the selection criteria contained herein.

Issuance of this RFA does not constitute an award commitment on the part of USAID, nor does it commit USAID to pay for costs incurred in the preparation and submission of an application. Further, USAID reserves the right to reject any or all applications received. In addition, final award of any resultant cooperative agreement(s) cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for award. Applications are submitted at the risk of the applicant. Should circumstances prevent award of a cooperative agreement, all preparation and submission costs are at the applicant's expense.

The preferred method of distribution of USAID procurement information is via the Internet. This RFA and any future amendments can be downloaded from the Agency Web Site. The World Wide Web Address is http://www.usaid.gov. Select Business and Procurement from the home page, then "USAID Procurements". On the following screen, select "Download Available USAID Solicitations". Receipt of this RFA through INTERNET must be confirmed by written notification to the contact person noted below. It is the responsibility of the recipient of the RFA document to ensure that it has been received from INTERNET in its entirety and USAID bears no responsibility for data errors resulting from transmission or conversion processes.

In the event of an inconsistency between the documents comprising this RFA, it shall be resolved by the following descending order of precedence:

(a) Section B - Selection Criteria;
(b) Section A - Grant Application Format;
(c) Section C - The Program Description;
(d) This Cover Letter.

Any questions concerning this RFA should be submitted in writing to Carey N. Gordon, via facsimile at 855-23-218-018 or via internet at cagordon@usaid.gov. If there are problems in downloading the RFA off the INTERNET, please contact the USAID INTERNET Coordinator at (202) 712-4442. Applicants should retain for their records one copy of all enclosures which accompany their application.

Thank you for your interest in USAID/Cambodia activities.

Sincerely,

Carey N. Gordon
Agreement Officer
USAID/Cambodia

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SECTION A - GRANT APPLICATION FORMAT

1. PREPARATION GUIDELINES

a. All applications received by the deadline will be reviewed for responsiveness and programmatic merit in accord with the specifications outlined in these guidelines and the application format. Section B addresses the technical evaluation procedures for the applications. Applications shall be submitted in two separate parts: (a) technical, and (b) cost or business application. Three hard copies of each part shall be submitted in addition to the email submission as described in the cover letter of this RFA.

b. The application shall be prepared according to the structural format set forth below. Applications must be received no later than the date and time indicated on the cover page of this RFA, to the location stated in the cover letter accompanying this RFA. Applications which are received late or are incomplete run the risk of not being considered in the review process. Such late or incomplete applications will be considered in USAID's sole discretion depending on the status of USAID's application review process as of the time of receipt and the quality of other applications received.

c. Technical applications should be specific, complete and presented concisely. A lengthy application does not in and of itself constitute a well thought out proposal. Applications shall demonstrate the applicant's capabilities and expertise with respect to achieving the goals of this program. The applications should take into account the technical evaluation criteria found in Section B.

d. Page Limitation and Unnecessarily Elaborate Applications: The length of the Technical proposal shall not exceed 50 (fifty) pages. THE PERFORMANCE MONITORING AND EVALUATION PLAN, PAST PERFORMANCE INFORMATION AND PERSONNEL RESUMES ARE EXCLUDED FROM THIS PAGE LIMITATION. In addition, there is no page limitation on the Cost Proposal. However, unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this RFA are not desired and may be construed as an indication of the prospective recipient's lack of cost consciousness. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

e. Explanations to Prospective Recipients: Any prospective applicant desiring an explanation or interpretation of this RFA must request it in writing to the Agreement Officer. Oral explanations or instructions given before award of a Cooperative Agreement will not be binding. Any information given to a prospective grantee concerning this RFA will be furnished promptly to all other prospective grantees as an amendment of this RFA, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective grantees.

f. Applicants should retain for their records one copy of the application and all enclosures which accompany their application. Erasures or other changes must be initialed by the person signing the application. To facilitate the competitive review of the applications, USAID will consider only applications conforming to the format prescribed below.

g. Acknowledgement of Amendments to the RFA - Applicants shall acknowledge receipt of any amendment to this RFA by signing and returning the amendment. The Government must receive the acknowledgement by the time specified for receipt of applications.

h. Submission of Applications by Email (**Important**):

1. Preferred software for email attachment: Microsoft Word (for narrative text) or Excel (for tables). Please convert your documents to one of these software programs before sending them to USAID. If we convert them for you, the resulting formatting may not be what you would like us to be reviewing.

2. After you have sent your proposals by email, please immediately check your own email to confirm that the attachments you intended to send were indeed sent. If you discover an error in your transmission, please send the material again and **note in the subject line of the email that it is a "corrected" submission**. Please do not wait for USAID to advise you that certain documents intended to be sent were not sent, or that certain documents contained errors in formatting, missing sections, etc. Each applicant is responsible for its submissions, so please inspect your own emails.

3. Please do not send the same email to us more than one time unless there has been a change, and if so, please note that it is a corrected email. If you send multiple copies of the same email, we do not know if there has been any change from one email to the next.

4. Your organization should appoint one person to send in the email submissions. If we receive email submissions from more than one person in your organization, we do not know who the authorized person is, and we cannot tell whether there has been a change from one email to the next without considerable effort on our part.

5. If you send your application by multiple emails, please indicate **in the subject line of the email** whether the email relates to the technical or cost proposal, and the desired sequence of multiple emails (if more than one is sent) and of attachments (e.g. "no. 1 of 4", etc.). For example, if your organization's name is Acme Consulting, and your cost proposal is divided and being sent in as two emails, the first email should have a subject line which says: "Acme, Cost Proposal, Part 1 of 2". If you do not do this clearly, we may not be sure of the correct order of the separate parts of your application. Our preference would be that each technical and each cost proposal be submitted as a single email attachment, e.g. that you consolidate the various parts of a technical proposal into a single document before sending it. But if this is not possible, please provide instructions on how the multiple parts are supposed to fit together, especially the sequence. What is obvious to you as the preparer of the document may not be obvious to us. Your application may not get optimal treatment if we are confused regarding the order and composition of your application .

i. The hard copies of applications and modifications thereof shall be submitted in sealed envelopes or packages addressed to the office specified in the cover letter of this RFA, with the RFA number, the name and address of the applicant, and whether the contents contain technical and/or cost proposals noted on the outside of the envelopes/packages.

j. Telegraphic applications will not be considered; however, applications may be modified by written or telegraphic notice, if that notice is received by the time specified for receipt of applications.

k. Preparation of Applications:

1. Applicants are expected to review, understand, and comply with all aspects of this RFA. Failure to do so will be at the applicant's risk.

2. Each applicant shall furnish the information required by this RFA. On the hard copies of applications, the applicant shall sign the application and certifications and print or type its name on the Cover Page of the technical and cost applications. Erasures or other changes must be initialed by the person signing the application. Applications signed by an agent shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.

3. Applicants which include data that they do not want disclosed to the public for any purpose or used by the U.S. Government except for evaluation purposes should:

(a) Mark the title page with the following legend:

"This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this application. If, however, a grant is awarded to this applicant as a result of - or in connection with - the submission of this data, the U.S. Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the

U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in pages___ ."; and

(b) Mark each sheet of data it wishes to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application."

l. Grant Award:

1. The Government may award one or more cooperative agreements resulting from this RFA to the responsible applicant(s) whose application(s) conforming to this RFA offers the greatest value in terms of the selection criteria (see Section B of this RFA). The Government may (a) reject any or all applications, (b) accept other than the lowest cost application, (c) accept more than one application, (d) accept alternate applications, and (e) waive informalities and minor irregularities in applications received.

2. The Government may award one or more cooperative agreements on the basis of initial applications received, without discussions or negotiations. Therefore, each initial application should contain the applicant's best terms from a cost and technical standpoint. The Government reserves the right (but is not under obligation to do so) to enter into discussions with one or more applicants in order to obtain clarifications or additional detail, or to suggest refinements in the program description, budget, or other aspects of an application.

3. A written award mailed or otherwise furnished to the successful applicant(s) within the time for acceptance specified either in the application(s) or in this RFA (whichever is later) shall result in a binding cooperative agreement without further action by either party. Before the application's specified expiration time, if any, the Government may accept an application, whether or not there are negotiations after its receipt, unless a written notice of withdrawal is received before award. Negotiations or discussions conducted after receipt of an application do not constitute a rejection or counteroffer by the Government.

4. Neither financial data submitted with an application nor representations concerning facilities or financing, will form a part of the resulting cooperative agreement unless explicitly stated otherwise in the agreement.

m. Authority to Obligate the Government - The Grant Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed agreement may be incurred before receipt of either a fully executed Agreement or a specific written authorization from the Grant Officer.

2. TECHNICAL APPLICATION FORMAT

a. The technical application must set forth in some detail the conceptual approach, methodology, and techniques for the accomplishment of the stated objectives. The program should define, to the maximum extent possible at the application stage, results and benchmarks for monitoring progress in achieving the results. A draft internal monitoring and evaluation plan must be included.

b. Applicants are encouraged to propose innovative implementation designs to reach the desired results, and an aggressive but realistic schedule of performance milestones as steps toward reaching those results. USAID's philosophy to development assistance is guided by four core values: customer focus, results orientation, empowerment and accountability, and teamwork. The determination of successful performance will be based upon the achievement of the desired results and not merely the generation of activities. The process is expected to be dynamic and will be evaluated on an ongoing basis. If something does not work, or if progress toward achieving targets in not satisfactory, the Recipient must identify the reason and take steps to fix it. Above all, the Recipient must be prepared to answer the question: "Will what we are doing lead to the achievement of the desired results."

c. Applications will be evaluated based upon both the level of achievement proposed and the realism of the plan for reaching that level of achievement. Post-award recipient performance will be evaluated against the standards proposed by the applicant and accepted by the Government, so well-documented realism in the statement of these program objectives is essential.

d. It is recommended that an applicant study the selection/evaluation criteria outlined in Section B of the RFA and organize its proposal accordingly.

e. The applicant should discuss how resources will be organized to obtain expected results. The applicant should discuss fully the "what" and the "how" of its plan. The purpose of this approach is to allow the applicant greater creative freedom to develop a plan for resource organization and use.

f. Additional Information about the Institutional Capability (which includes past performance) and Staffing components of the Technical Plan: The Institutional Capability and Staffing components of the Technical Plan shall include the information specified in paragraphs i - iv, below.

i. Personnel Proposed. Specify the composition and organization structure of the entire implementation team (including home office support) and describe each staff member's role, technical expertise and estimated amount of time each will devote to the project. Indicate the names and provide resumes of all important managerial and technical personnel to be assigned to this program activity. Proposed personnel not yet identified may be shown as "TBD" (to be determined).

ii. Organizational Capability. Applicants must offer evidence of their technical resources and expertise in addressing relevant problems and issues. Care shall be taken to establish the relevance of past experience to this program and the basis for reliance upon that experience as an indicator of success on this program. Information in this section should include (but is not limited to) the following:

- Brief description of organizational history/expertise;
- Pertinent work experience and representative accomplishments in developing and implementing programs of the type required under the proposed RFA;
- Evidence of a successful record of implementing projects overseas, and in Cambodia, if applicable;
- Relevant experience with proposed approaches;
- Institutional strength as represented by breadth and depth of experienced personnel in project relevant disciplines/areas;
- Sub-recipient capabilities and expertise;
- Proposed field management structure and financial controls; and
- Home-office backstopping and its purposes.

iii. Past Performance References. Applications must include a complete list of all U.S. Governmental and/or privately funded contracts, grants, cooperative agreements, etc. received by your organization in the last three fiscal years involving programs similar to the program proposed in your application. Include the following for each award listed:

- Name of awarding organization or agency;
- Address of awarding organization or agency;
- Place of performance of services or program;
- Award number;
- Amount of award;
- Term of award (begin and end dates of services/program);
- Name, current telephone number, current fax number, and Internet address (if one is available) of a responsible technical representative of that organization or agency; and
- Brief description of the program.

iv. Subgrantees/Subcontracts: Organizations may not possess all the skills required to achieve all the results identified in this RFA. Organizations are urged to enter into partnerships with other non-profit and for profit organizations as sub-grantees or sub-contractors to supplement skills. However, **one organization shall be designated to serve as the prime organization** and will be responsible for the achievement of results and the implementation of the program. If the

applicant plans to collaborate with other organizations, government agencies or indigenous organizations for the implementation of the award, the services to be provided by each agency or organization shall be described. Applicants which intend to utilize subgrantees and/or subcontractors shall indicate the extent intended, the method of identifying them and the tasks/functions they will be performing. Applicants shall state whether or not they have existing relationships with these other organizations and the nature of the relationship (e.g., subgrantee, subcontractor, partnership etc). The applicant must specify the technical resources and expertise of proposed subcontract/subrecipient organizations. Technical plan information for proposed subgrantees and/or subcontractors should follow the same format as that submitted by the applicant.

3. COST APPLICATION FORMAT

The Cost or Business Application is to be submitted under separate cover from the technical application. Certain documents are required to be submitted by an applicant in order for the Grant Officer to make a determination of responsibility. However, it is USAID policy not to burden applicants with undue reporting requirements if that information is readily available through other sources.

The following sections describe the documentation that applicants for Assistance award must submit to USAID prior to award. While there is no page limit for this portion, applicants are encouraged to be as concise as possible, but still provide the necessary detail to address the following:

A. Include a budget with an accompanying budget narrative which provides in detail the total costs for implementation of the program your organization is proposing. Detailed **budget notes** and supporting justification of all proposed budget line items should be included.
The budget submitted shall include a completed Standard Form 424 and 424A which can be downloaded from the USAID web site, http://www.usaid.gov/procurement_bus_opp/procurement/forms/sf424/;

- the breakdown of all costs associated with the program according to costs of, if applicable, headquarters, regional and/or country offices;

- the breakdown of all costs according to each partner organization (or sub-awardee) involved in the program;

- the costs associated with external, expatriate technical assistance and those associated with local in-country technical assistance;

- the breakdown of the financial and in-kind contributions of all organizations involved in implementing this Cooperative Agreement;

- potential contributions of non-USAID or private commercial donors to this Cooperative Agreement;

- your procurement plan for commodities (**note** that contraceptives and other health commodities will not be provided under this Cooperative Agreement).

- Other instructions for preparation of proposed budgets:

- (1) Indicate the name, annual salary, and expected level of effort of each person charged to the proposal. Provide resumes showing work experience and annual salary history for at least the three most recent years for major personnel.

(2) If not included in the indirect cost rate agreement negotiated with the U.S. Government, specify the applicable fringe benefit rates for each category of employees, and benefits included in the rate.

(3) The same individual information for consultants shall be provided as for regular personnel.

(4) Allowances shall be broken down by specific type and by person, and must be in accordance with the applicant's policies.

(5) Travel, per diem and other transportation expenses shall be detailed in your proposal to include number of international trips, expected itineraries, number of per diem days and per diem rates.

(6) Specify all equipment to be purchased and the expected geographic source.

(7) Financial Plans for all proposed subgrants and subcontracts shall have the same format and level of detail as those of the applicant.

(8) Other direct costs such as supplies, communication costs, photocopying, visas, passports and other general costs should be separate cost line items.

B. A copy of your organization's current Negotiated Indirect Cost Rate Agreement, if you have one with a US federal agency;

C. Required certifications and representations (as attached below):

D. Details regarding the level of cost share your organization is proposing for this activity. While there is no stated minimum required cost share amount, applicants are encouraged to give serious consideration to the amount they propose as a signal of the applicant's commitment to the activity (see also sec. B. selection criteria under costs).

E. Applicants who do not currently have a Negotiated Indirect Cost Rate Agreement (NICRA) from their cognizant agency (USAID or another agency of the US federal government) shall also submit the following information:

1. Copies of the applicant's financial reports for the previous 3-year period, which have been audited by a certified public accountant or other auditor satisfactory to USAID;

2. Projected budget, cash flow and organizational chart;

3. A copy of the organization's accounting manual.

F. Applicants shall submit any additional evidence of responsibility deemed necessary for the Grant Officer to make a determination of responsibility. The information submitted should substantiate that the Applicant:

1. Has adequate financial, management and personnel resources and systems or the ability to obtain such resources as required during the performance of the award.

2. Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the applicant, non-governmental and governmental.

3. Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance.

4. Has a satisfactory record of integrity and business ethics; and

5. Is otherwise qualified and eligible to receive a grant under applicable laws and regulations (e.g., EEO).

G. Applicants that have never received a grant, cooperative agreement or contract from the U.S. Government are required to submit a copy of their accounting manual. If a copy has already been submitted to the U.S. Government, the applicant should advise which Federal office has a copy.

H. Certificate of Compliance: Please submit a copy of your Certificate of Compliance if your organization's systems have been certified by the USAID/Washington's Office of Procurement.

SECTION B - SELECTION CRITERIA

The criteria presented below have been tailored to the requirements of this RFA. The relative importance of each criterion is indicated by approximate weight by points, of which 100 points are possible for technical and 10 points for cost issues. The Applicant should note that these criteria serve to identify the significant matters, which Applicants should address in their applications, and to set standards against which all applications will be evaluated. To facilitate the review of applications, Applicants are requested to organize the narrative sections of technical proposals according to the evaluation criteria set forth below.

Applications will be evaluated in accordance with the evaluation criteria set forth below. The criteria are:

I. ILLUSTRATIVE PROGRAM APPROACH [30 points]

1. Demonstrated understanding of the appropriate, cost-effective health system strengthening interventions/approaches most likely to have a significant impact on achieving the Mission's strategic objective in the health (PHN) sector.

2. Merit of the proposed illustrative implementation plans in terms of its ability to achieve the strategic objective, taking into consideration the health needs of Cambodians.

3. Appropriateness of the Applicant's description of linkages of the Health Systems Strengthening component with the other components of USAID's integrated health program (e.g., maternal and child health, reproductive health, HIV/AIDS, etc.)

4. Strength of the analysis of potential obstacles, risks and problems that could be encountered during program implementation and feasibility of the proposed solutions for addressing the identified problems.

5. Merit of the Applicant's approach to ensure that the program results can be sustained after completion of the three-year implementation program.

6. Approach to institutional development of local organizations that will implement this component.

II. COLLABORATION AND TEAM WORK [20 points]

1. Strength and appropriateness of the proposed partnership (local and/or international organizations) that are awarded the cooperative agreement for this program.

2. Merit of proposed relationships between headquarters/support office and the planned Cambodia office and adequacy of local delegation of responsibility.

3. Merit of the proposed approach for working with cooperating agencies and their local partners implementing the other components of the USAID-supported Cambodia program, with local development organizations, host government, donors and USAID in assuring on-going collaboration of field implementation efforts to achieve the results and support the national health program.

III. INSTITUTIONAL CAPABILITIES OF THE APPLICANTS [20 points]

1. Demonstrated knowledge, capability and long term experience of the Applicant in providing Health Systems Strengthening in areas or countries with similar conditions to those of Cambodia.

2. Merit of proposed organization of the Applicant's Cambodia and headquarters/support office and extent to which the Applicant's proposed organizational structure is managerially streamlined, practical and efficient.

3. Strength of the illustrative work plan to ensure a smooth and effective launch of program implementation.

IV. STAFFING [30 points]

1. Merit of critical professional staff for program implementation in terms of:

   a. Demonstrated experience and competency in the implementation of health systems strengthening programs;
   b. High level experience in technical fields appropriate to proposed positions and roles;
   c. Experience in coordinating diverse activities that produced documented results;
   d. Demonstrated experience in the use of varied modalities (e.g., technical assistance, technology transfer, training, information dissemination) to transfer concepts and skills;
   e. Experience in cost analysis, pricing, cost recovery;
   f. Experience in working with or knowledge of USAID-supported cooperating agencies, donors, USAID missions, and international counterpart organizations;
   g. Relevant experience working in developing countries, particularly Cambodia (Khmer language capability is viewed favorably); and
   h. Extent to which the proposed staff's skills complement one another.

2. Appropriate number and skills mix of the staff proposed to for implementation and on-going program monitoring.

V. COST CONSIDERATIONS [10 points]

1. Cost effectiveness and realism.

2. Adequacy of budget detail and financial feasibility

3. Cost-sharing contribution.

Subject to the availability of funds, USAID expects to award one cooperative agreement. An award will be made to the responsible Applicant(s) whose application offers the greatest value, cost and other evaluation factors considered.

Applications will be ranked in accordance with the selection criteria identified above. USAID reserves the right to determine the resulting level of funding for the cooperative agreement.

SECTION C - PROGRAM DESCRIPTION

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SECTION I: BACKGROUND

A. THE DEVELOPMENT CHALLENGE IN THE CAMBODIAN CONTEXT:

The United States was one of the principal architects of the 1991 Paris Peace Accords, which effectively ended decades of civil war in Cambodia. Our national interest lies in assuring that our investment in that process is not lost. The United States' main foreign policy objectives in Cambodia are promotion of democracy, good governance and continued improvement of human rights. Addressing global problems of infectious diseases, especially HIV/AIDS and TB, and serious concerns related to maternal and child health are also high priorities.

The current USAID program in Cambodia traces its roots to humanitarian assistance in support of Cambodian non-communist resistance groups and displaced Cambodians along the northwestern border with Thailand beginning in 1986. With the signing of the Paris Peace Accords in 1991, U.S. assistance accelerated sharply. The Cambodia program evolved towards a more traditional USAID program with emphasis on meeting basic human needs throughout the country and, supporting the UN-lead initiative to establish a freely elected government. By the mid-1990s, the program emphasis had shifted toward building the foundations for democratic governance and sustainable economic growth through support for nation-building efforts, establishment of effective delivery systems for basic health and education services, and promotion of sound management of the environment and natural resources.

The current USAID interim country strategic plan covers the three-year period 2002 to 2005. Prevailing legislative restrictions and the country's political environment, preclude the development of a long-term sustainable development strategy at this time.

Within the time frame of this plan, Cambodia will hold its third national elections, currently scheduled for mid-2003. The process and the outcome of these elections may well shape the nature and scope of future USAID assistance. The elections themselves provide a window of opportunity for more focused support to the promotion of democratic practices.

The recent easing of US legislative restrictions related to HIV/ AIDS, infectious diseases, anti-trafficking and basic education acknowledges the severity and urgency of these problems, as well as the Royal Government of Cambodia's (RGC) commitment to reform in these areas.

The USAID Interim Country Strategy for 2002 to 2005 is the result of an extensive assessment process that greatly benefited from inputs from USAID/Washington, officials of the Royal Government of Cambodia, USAID's NGO partners and contractors, other donors, and representatives from a wide range of Cambodian and international NGOs. This strategy has been designed to respond to changes in the overall assistance environment, take advantage of the immediate opportunities available within this time frame, and strategically contribute to the achievement of U.S. foreign policy objectives in Cambodia.

This interim strategy takes full advantage of opportunities for achieving strategic results within the three-year time frame of the strategy, and for scaling up successful efforts in areas where there is commitment on the part of the RGC to proceed. Although USAID's program in Cambodia will continue to focus on the promotion of democratic practices and human rights, prevention of HIV/AIDS, and addressing maternal and child health concerns, the nature of activities under this interim strategy will be significantly different in scope and scale from the current program. Under the new strategy, the Cambodia mission will consolidate and focus its efforts

to achieve some significant and sustainable results within the changing development assistance environment, and strategically contribute to the achievement of U.S. foreign policy objectives in Cambodia.

USAID will focus on a rapid scale-up and national level expansion of successful HIV-prevention interventions, combined with strengthening of health systems to meet reproductive, family health and infectious disease needs of Cambodia's largely rural population. This combined approach replaces separate programs in HIV/AIDS and reproductive and child health.

USAID grantees will be assisted to develop and test community-based approaches for care and support of those infected by HIV/AIDS. Voluntary counseling and testing programs will be expanded. Continued support will be provided to Cambodia's HIV/AIDS surveillance system to monitor the epidemiological and behavioral trends of the epidemic. These efforts are key to helping Cambodian NGOs and health authorities balance prevention and care efforts, and developing and targeting appropriate prevention messages. USAID will also fund technical assistance, social marketing, and public awareness campaigns at the national and provincial levels to help prevent HIV, address issues related to HIV-TB co-infection, and reduce the stigma associated with the disease.

USAID efforts in health systems strengthening will focus on technical assistance, training and service provision. The focus will be on certain operational districts in several provinces where combining activities in HIV/AIDS, maternal and child health, reproductive health and infectious diseases will result in a strengthened health system and better quality services that are appropriately utilized by increased numbers of satisfied clients. (See Attachment 1 of RFA section E for a listing of these districts). Support will be provided for skills training for health providers and the development of a referral system to provide emergency obstetric care. USAID activities will make contraceptive information and services routinely available at the community level; increase the availability and effectiveness of antenatal services and outreach antenatal services; provide tetanus toxoid and anemia prophylaxis; and diagnose and treat sexually transmitted infections (STIs), TB, dengue fever and malaria. This program will also train health providers in standard clinical management practices for infectious diseases, and in the design of interventions aimed at public and private health providers, drug dispensers, and consumers in order to improve the quality of drugs and decrease the inappropriate use of drugs and other medications.

SECTION II: PROGRAM GUIDELINES

The United States Agency for International Development in Cambodia (USAID/C) is in the process of developing an integrated PHN program for the next phase of assistance from 2002-2005. USAID/C's approved strategic objective for the population, health and nutrition sector is: "Increased Use of High Impact HIV/AIDS and Family Health Services and Appropriate Health Seeking Behaviors." This strategic objective is bolstered by four interconnected Intermediate Results: (IR1) Increased access to information and services; (IR2) Strengthened capacity of individuals, families and communities to protect and provide for their own health; (IR3) Improved quality of information and services; and (IR4) Improved capacity of health systems. The process by which USAID/C has chosen to develop this program is based on the Agency's core values. These core values and what they mean for this new program effort are elaborated below.

USAID'S CORE VALUES: USAID's four core values are: (1) customer focus; (2) teamwork; (3) results orientation; and (4) empowerment and accountability. Throughout the implementation of this program, the work of USAID/C and its partners (including RGC) will be guided by these four core values.

Customer Focus: USAID has defined its "ultimate customers" as socially and economically disadvantaged people, primarily the most vulnerable women and children. They are the intended end users of U.S. assistance.

USAID/C has not conducted a formal customer survey, as other Missions sometimes do to assess the stated needs of its ultimate customers. However, USAID/C and its partners have used other types of information, surveys and anecdotal data to shape its strategy and activities so that they are focused for the direct benefit of its customers—the socially and economically disadvantaged Cambodian women, children, and men.

USAID/C recognizes that intermediaries usually exist between USAID and its ultimate customers. Although these intermediaries in some contexts could also be considered USAID's customers, USAID has reserved the term to refer to the intended end users of U.S. assistance—the poor and disadvantaged, especially the most vulnerable women and children. Partners work directly with USAID to affect the circumstances of customers. "Stakeholders", or intermediate customers, influence the circumstances of customers but are not funded directly by USAID. USAID/C acknowledges the importance of its customers and its partners. USAID/C has tried to build into its program the components/activities that take into account the interests of its partners while addressing the needs of its ultimate customers. In this way, it has sought to maximize development results.

While an interest in customers is not new to USAID, customer focus has increasingly been strengthened to provide earlier recognition of and more active and prominent attention to, the role of customers' own perceptions of their own needs and concerns. In this way, USAID expects to make progress in delivering measurable and sustainable development results.

The partners will join with USAID/C, RGC, and other local donors and partners to articulate a new 3-year umbrella workplan for 2002-2005 to produce an overarching results framework and more complete and comprehensive annual workplans to produce specific results. The strategic framework (Attachment B) is a narrative statement or graphical representation of the development hypothesis indicating the longer term results, their causal relationships and underlying assumptions necessary for achieving a strategic objective. The framework also establishes an organizing mechanism for measuring, analyzing, and reporting on the results attendant to achieving the strategic objective. Annual workplans will also be articulated and consist of human resources, funding, authorities, activities, targets and indicators, and associated documentation required for achieving a specified result(s) within an established time frame. These will be consistent with USAID/C's new Interim PHN strategy, RGC/MOH strategic plans from National Programs (“vertical” programs), and other documents which will be supplied to the partners.

Teamwork: Teams are groups of individuals coming together on a common approach to achieve agreed upon objectives. Teams function in a collaborative and supportive fashion, drawing on the strengths of individual members. They work best when these individual strengths are combined into a congregation of interested parties working effectively because they have agreed to this union and because they understand that "together each achieves more." Moreover, by collaborating on a mutually agreed set of objectives, teams ensure that redundancies are reduced or eliminated and that complementarities and interrelationships are enhanced.

USAID/C anticipates forming two basic teams for the purpose of overseeing the strategy and activities. One, the core team of USAID personnel ultimately responsible for carrying out the U.S. government's responsibilities related to the program, has already been formed and is currently functional. It is called the Office of Public Health. The other is an expanded team, which includes the USAID core team, the partners, and host government representatives, as appropriate, for consultation under current U.S. Congressional legislation. The core team will have leadership and quality control responsibilities over the overall process.

In the context of the PHN program in Cambodia, teams will be expected to function on three levels: first, each participating partner will be expected to organize its staff on a team basis to achieve individual component results. Second, each partner will be expected to work on a USAID program-wide expanded team with other partners (including USAID and RGC, as appropriate) to ensure that all components are working together in a coordinated fashion and toward the mutually agreed common program goals. Third, each partner will be expected to work, as appropriate, with other donors in achieving the goals of the larger national health program in Cambodia.

Results Orientation: Results represent changes in conditions that USAID and its partners seek to influence through the provision of development assistance. A results orientation is defined as managing for the achievement of results. This means establishing a "results framework" or workplan which includes setting the intermediate results necessary to achieve the strategic objectives, and underlying causal relationships and assumptions. A results framework also establishes the basis for measuring, analyzing, and reporting results. Work is organized in a way that keeps USAID and its partners focused on intended results (not inputs), and progress is assessed on a regular basis using agreed performance indicators and targets.

USAID/C and its partners (including RGC), as appropriate, will jointly discuss and agree upon a results framework as part of the overall process. As trends in progress are assessed, intermediate results and annual workplans may be adjusted, based on discussion and mutual agreement, to ensure the best results possible.

Empowerment and Accountability: To achieve its objectives, an organization that focuses on the results of its services to customers has to place authority for decisions as close as possible to where the impact is achieved. Furthermore, to promote participation, those in authority must be able to use their own initiative, take considered risks, and be able to respond to opportunities. To ensure the wise and ethical management of resources, accountability for managing resources strategically to accomplish stated developmental objectives must accompany authority.

All partners (including RGC, as appropriate, and USAID) will form an expanded team in which: (1) the results framework for the PHN strategy will be developed through an iterative and collegial process; and (2) three-year and annual plans for the implementation of this framework will be made. Detailed plans and anticipated intermediate results will include assignments of responsibility to specific partners. The results framework and workplans will be consistent with the population, health and nutrition information and service needs of USAID's customers and USAID/C's new strategic objective and intermediate results. Because both USAID and RGC will be in close consultation, it will be their responsibility to ensure full agreement with the program/activities as it progresses and that it fits within the overall strategies, goals and objectives of the national health program as it develops. Once the partners have completed their work, USAID will ensure appropriate documentation, authorizations to formalize the implementation plan, and the obligation of funds.

Once the implementation stage has started in late 2002, each partner will be empowered and accountable for achieving its portion of the plan and related results in coordination with the other grantees, as agreed. The full implementation team (including USAID and RGC, if/as appropriate) will be empowered and accountable for achieving the program’s strategic objective. The full team will therefore need to meet regularly in order to monitor the program’s overall progress and make adjustments, if necessary.

SECTION III: THE HEALTH SECTOR IN CAMBODIA

This section describes the type and scope of activities to be undertaken, and the results to be achieved with the funds under this Agreement as USAID focuses on the twin challenges of rapid scale-up and national level expansion of successful HIV-prevention interventions, combined with strengthening of health systems in selected areas to meet reproductive, family health and infectious disease needs of Cambodia's largely rural population.

USAID's NGO partners have penetrated rural areas with high-impact child survival programs through village development committees, increased the proportion of women seeking antenatal care, and provided high quality care for obstetric complications in areas where none was available before. USAID implements family planning and reproductive health activities through local NGOs, with an emphasis on strengthening their capacity. National population policies in Cambodia affirm the right of women to have access to contraception and emphasize birth spacing and safe motherhood. Sale of contraceptive pills through social marketing initiatives increased 87% in one year. The Reproductive Health Association of Cambodia (RHAC) generated a 60% increase in outreach to clients in one year.

The RGC's positive policy environment related to reproductive health, safe motherhood, HIV/AIDS and infectious diseases has enabled USAID to achieve significant progress in the health sector over the past four years. In reproductive and child health, USAID support has played a critical role in increasing contraceptive prevalence using modern methods from 6.9% in 1996 to 19.1% in the year 2000; reducing infant mortality from 115 per 1000 live births in 1996 to 95 per 1000 in 2000; decreasing child mortality from 181 per 1000 to 124.5 per 1000 over the same period; and, decreasing HIV/AIDS prevalence from 3.2% in 1997 to 2.3% in 2000 among pregnant women attending antenatal clinics.

As a continuance of its assistance, USAID/C and its implementing agencies and their local partners will work together with the Royal Government of Cambodia and its development partners to ***increase use of high impact HIV/AIDS and family health services and appropriate health-seeking behaviors*** over the next phase of assistance from 2002-2005. Activities undertaken to achieve this strategic objective will ensure the achievement of the following four IRs:

- Access to information and services is increased;
- Capability of individuals, families and communities to protect and provide for their own health is strengthened;
- Quality of information and services is improved; and
- Capacity of health systems is improved.

Working in collaboration with government (RGC), international non-governmental organizations (I/NGOs), local non-governmental (NGOs), private commercial sector partners and other donors, USAID assistance will support critical elements of the primary health care information and service delivery system and help strengthen the overall health system. USAID assistance will ensure that access to information and the utilization of essential services (including a comprehensive package of HIV/AIDS prevention and care; reproductive health; maternal and child health; prevention and treatment of sexually-transmitted infections) and the control of selected infectious diseases (i.e., TB, malaria and dengue), will continue. USAID assistance will also improve and strengthen the existing health system and its requisite systems (administrative, management, health information, quality assurance, supervision and monitoring, logistics/reporting and service delivery systems). It will support the Government's decentralization efforts by strengthening the institutional, management, and technical capabilities of provincial and operational district health offices and facilities. Finally, USAID assistance will strengthen the management and technical capabilities of local non-governmental and community organizations in order to improve and expand NGO/CO involvement in the delivery of health information and services at the community level and in concert with the government's priorities.

Currently, USAID is supporting the provision of health care information and services and selected aspects of the health care delivery system through activities that are implemented by I/NGOs, local NGOs, community organizations (COs) and international organizations. USAID is working to preserve, strengthen and appropriately expand the following health care services and information: a comprehensive package of HIV/AIDS prevention and care; reproductive health; maternal and child health; prevention and treatment of sexually-transmitted infections; and, the control of selected infectious diseases – TB, malaria, dengue).

PHN Strategy Priorities:

The following are USAID's priority program areas for the duration of the 3-year PHN Interim Strategy:

- Child health
- Maternal health
- Reproductive health
- HIV/AIDS
- Infectious diseases

Factors Influencing the Selection of Interventions

The new strategy is based on historical experience, lessons learned, RGC strategies and priorities, and pragmatic decisions for the future. Activities and interventions have been selected based on the following principles and factors:

- Working closely with our Cambodian and other donor partners under the umbrella of RGC national strategies and policies;
- Integrating HIV/AIDS and RH/MCH health education/health promotion and service delivery programs wherever feasible to build upon synergies and preserve scarce resources;
- Concentrating health assistance in key provinces and operational districts (OD) to achieve a critical mass and enable Cambodians to make the choices that will improve their health;
- Ensuring that capacity building is part of every activity that USAID supports.
- Targeting the most strategic or vulnerable segments of the population;
- Supporting a cost-effective primary and preventive health service paradigm;
- Preserving progress already made;
- Building on existing RGC policies and indigenous health infrastructure (public, NGO and private sector);
- Building on programs/activities to strengthen financing mechanisms which will enable low-income segments of the population to pay for health services;
- Recognizing the need to improve existing health information and service delivery efforts and scaling up innovative and effective programs in other priority provinces/ODs.

NOTE OF INSTRUCTION:

The sections below outline the health interventions that USAID/C anticipates will be undertaken by eight cooperating agencies and their local partners currently working in Cambodia. For the purposes of this RFA, these grantees are referred to as "service delivery organizations." Additional cooperating agencies, funded through USAID/Washington centrally managed agreements, will complement the service delivery components

with policy, operations and other research, information dissemination, and technical assistance in tuberculosis control and other infectious diseases.

This RFA is only for the Health Systems Strengthening component of the Interm PHN Strategy and is expected to provide technical assistance, training and service provision in full collaboration with the service delivery organizations, the MOH and National Programs, other donors and local organizations (NGO and private sector). The Applicant is expected to address areas of complementarity, synergy and shared opportunities across the integrated PHN strategy.

The strategy and funding parameters fully reflect Cambodia's status as a rapid scale-up country for HIV/AIDS, and priority for TB control. The health sector in Cambodia faces enormous and persistent challenges:

HIV/AIDS challenges: The HIV/AIDS prevalence rate in Cambodia remains the highest in Southeast Asia. Prevention is hampered by low use of condoms with intimate partners, a lack of counseling and testing services, and a paucity of information and services geared to the needs of especially vulnerable groups such as youth and internal migrant populations.

Safe motherhood challenges: Cambodia's maternal mortality rate is the highest in the region. This is directly related to low antenatal attendance at health centers; low level of deliveries assisted by trained health providers; and, harmful traditional practices during pregnancy, childbirth and postpartum. Most maternal deaths are due to complications related to unsafe induced abortion or direct obstetric causes.

Family planning/birth spacing challenges: Low contraceptive prevalence; large unmet needs and demands for family planning services; and, a high prevalence of unsafe abortions.

Child health challenges: High infant, child and neonatal mortality rates; low use of oral rehydration salts; low EPI coverage; low rates of exclusive breastfeeding of infants below five months of age; and, indiscriminate use of antibiotics for childhood infections.

Infectious diseases challenges: Tuberculosis, malaria and dengue hemorrhagic fever continue to be leading causes of morbidity and mortality. HIV/AIDS-TB co-infection is increasing rapidly.

Service delivery challenges: The still nascent public health system is not yet playing a major role in responding to these public health challenges. The system's existing workforce, while perhaps large in number, is not adequate in appropriate skills. Salaries are so low as to create little or no incentive to work. Supplies and equipment at health centers are not adequate or appropriate for many health care situations. The general population relies heavily on private service providers who most often have little or no medical knowledge and per capita out-of-pocket expenditures for inappropriate or inadequate health care are excessive.

Existing health services: The RGC launched its ongoing health sector reform program in 1995 with the presentation of the National Health Coverage Plan for 1996-2000. Key features of the plan included the creation of the Operational District (OD) – a population-based unit comprising anywhere from 100,000 to 300,000 people – as the functional focus of health reform efforts; designation of health centers (HC) as the first level of health care; and, a stated intention to provide a Minimum Package of Activities (MPA), and Complementary Package of Activities (CPA) at the health centers and referral hospitals respectively. The plan called for the establishment of 940 health centers. As of late 2001, approximately 700 health centers were in place (75% of the total) in 74 ODs around the country. Of the 67 referral hospitals called for in the plan, only 15 are currently in place. Only 55% of the population had geographic access to primary-level health facilities in

2000, defined as living within a 10 km radius or two-hour walk of a health center. Priority has been given to establishing the physical infrastructure and strengthening clinical services; outreach has not been a high priority. The range and quality of services offered at these facilities vary widely.

The bulk of Cambodia's public health system staff was recruited and trained quickly during the period 1979-89. Many of the skills these new personnel learned are not adequate to respond to the country's burden of disease. Moreover, the planning, management and supervisory systems and skills needed to support the health care delivery system are similarly weak. Local and international NGOs are helping to fill this gap in many important ways but such heavy reliance on external assistance should not delay the strengthening of the public health system's own capacity to meet basic health care needs.

Most Cambodians look to non-government outlets (pharmacies, traditional healers, drug sellers) as their preferred sources of services for most health problems including delivery assistance, birth spacing methods, STD drugs and abortion. An uncontrolled drug industry and widespread self-treatment have serious implications for the quality and appropriateness of treatment. A number of studies have suggested that very few of the personnel at non-government outlets are familiar with common symptoms of reproductive health problems, correct drug dosage or potential side effects, or correct management procedures for many of the health problems they treat. In consequence, most Cambodians are receiving very poor quality of care, and little value for their money, at either public or private sources of health services. Nevertheless, high household expenditures for health care are an enormous financial burden for many families, particularly in rural areas.

Opportunities for high-impact interventions

HIV/AIDS. While awareness of HIV/AIDS is high and concern is increasing in selected sites, the social and cultural environment is still highly permissive with a very active sex trade, unprotected high-risk behaviors, and potential risk for unsuspecting steady partners and/or wives. While there is evidence that behavior change has begun to occur for selected population groups that have been targeted to date, in general high-risk sexual behavior remains high.

The past three years' successes in reaching high-risk populations and changing behaviors demonstrate that Cambodians will act when provided adequate information and services. Most Cambodians, however, lack access to information, voluntary counseling and testing, condoms, STI diagnosis and treatment, antenatal care and birth spacing services – resulting in considerable unmet demand for these services, especially among high-risk and mobile populations that may put themselves at higher risk for infection and transmission.

While models of successful interventions with high-risk populations have been developed, the scope and coverage of these efforts have been limited. These models need to be significantly and rapidly scaled up to reach a broader segment of high-risk populations including police and military personnel, factory workers and commercial sex workers as well as other sub-populations at risk due to the behaviors of the so-called "bridging" populations. Successful approaches need to be expanded to other high-risk populations such as indirect sex workers, and migrant workers, truck drivers and other mobile populations.

Major opportunities to improve the technical quality of services, take full advantage of all available channels for HIV/AIDS prevention, and improve cost-effectiveness have been missed by channeling health services through various vertical structures. Service delivery needs to be integrated at the OD-level in order to ensure that links are made between HIV/AIDS and all other health interventions. This would entail defining and implementing the package of essential health services, the MPA and MPA+. 1 HIV/AIDS-related services that need to be

1 The MoH-sanctioned "Minimum Package of Activities-Plus" or MPA+, whereby the "plus" refers to HIV/AIDS and STD prevention activities.

strengthened at the OD-level include voluntary counseling and testing, STD diagnosis and treatment, and dissemination of more general information about HIV/AIDS. Integrated programming should result in higher impact and would contribute to the identification of approaches that could be replicated in other geographic areas by the RGC and other donors.

As the epidemic matures, issues related to women with HIV and pediatric AIDS, and care and support for those infected with and affected by HIV/AIDS have become more salient. OD-level interventions could contribute to the prevention of mother-to-child transmission of HIV through expansion of voluntary counseling and testing services. OD-level interventions would also foster synergies between HIV/AIDS and RH/FP/MCH and contribute to reducing overall maternal and child morbidity and mortality, consistent with USAID's global priorities and strategies in health.

Given the extremely limited capacity of the public health and social services systems, continued emphasis needs to be placed on developing and expanding effective community-based approaches to care and support of those infected and affected by HIV/AIDS.

Cambodia's HIV sentinel surveillance and behavioral surveillance systems, developed largely with USAID funding, have contributed significantly to effective program planning and creating a policy environment conducive to AIDS prevention. These systems need to be refined and expanded to include STI surveillance, new high-risk target groups and potentially elements of a population-based approach to better ascertain the level of spread in the general population.

Maternal health. Cambodia's very high levels of maternal, infant and child mortality are clear indicators of the limitations and weaknesses in existing health service delivery systems. The vast majority of Cambodian women (89%) deliver at home assisted by untrained birth attendants (65%), receive no antenatal care prior to delivery (62%), and no tetanus toxoid immunization (55%). Most pregnant women are anemic (a range of 50 to 80% across provinces), and suffer from Vitamin A and iodine deficiencies in selected provinces. Access to emergency obstetric care is extremely limited. Postpartum services are virtually non-existent, despite the fact that postpartum hemorrhage is a common killer and breastfeeding practices are poor. Delivery practices of traditional birth attendants are known to include harmful practices.

Within the context of an integrated health service delivery strategy at the provincial and OD-levels, there is clear need and opportunity to continue to upgrade the skills of midwives and foster linkages between midwives and TBAs in order to ensure access to necessary and appropriate antenatal and postpartum services, and reduce harmful delivery practices. NGOs and the private sector will continue to have an important role to play in outreach activities.

Family planning/birth spacing. Despite a rapid increase in contraceptive knowledge and use over the last five years, the unmet need for family planning services is considerable – due mainly to the absence of extensive service delivery systems. Although the government policy environment toward birth spacing is favorable and permits distribution of a complete range of contraceptive methods, the only methods currently available to any significant extent are pills, injectables and condoms. Even these methods are not readily available in rural areas. Anecdotal evidence suggests that this limited availability of birth spacing services is at least partially responsible for Cambodia's high incidence of unsafe abortions. Notably lacking is emergency contraception for which the need may be great given the reportedly high incidence of rape, which bears especially heavily on the adolescent population.

Contraceptive products need to be made routinely available at the community level by strengthening and expanding information and services through community-based approaches, thus moving beyond the current health center medical model. These approaches would extend and complement the outreach activities of the health center staff without undermining or competing with them. Increased availability could also be achieved through expanding partnerships with private providers of reproductive health services, expanding social marketing in rural areas, and improving the health system's capacity to provide post-abortion care.

Expanded voluntary family planning services at the OD-level would address the needs of married couples not yet using a contraceptive method, and who have said they want to limit or prevent future pregnancies. IEC efforts are needed to promote the practice of three-year birth intervals. Expanded OD-level services would also respond to the needs of a large group of women who resort to abortion as a means of achieving their fertility preferences and provide post-abortion care. Adolescents at risk of unwanted pregnancies, especially in the burgeoning garment industry and the growing urban middle class, need specially designed youth-friendly information and services, including emergency contraception.

Child health. The chief causes of infant and child mortality are neonatal tetanus, acute respiratory infection, diarrhea, meningitis, septicemia, typhoid, malaria, and dengue. Child health service coverage is extremely low: the majority of children are not fully immunized (60%), do not receive Vitamin A prophylaxis (51%), oral rehydration therapy (62%), or treatment for ARI by a trained provider (60%). Half the children are malnourished. While breastfeeding is universal, less than 6% of babies are breastfeed exclusively for five months, and few are breastfed immediately after birth.

Child health interventions need to be strengthened within the context of the MPA+ package, with special emphasis on ARI, diarrhea and malnutrition (particularly optimal breastfeeding and infant feeding practices and use of micronutrients, especially Vitamin A). There are also opportunities to work with UNICEF and WHO to support the RGC's pilot testing of Integrated Management of Childhood Illness (IMCI), and to scale up that activity in selected ODs.

Infectious diseases. Tuberculosis (TB), malaria and dengue hemorrhagic fever (DHF) continue to be leading causes of morbidity and mortality. The emergence of drug-resistant malaria strains has been confounded by extensive national and cross-border mobility. There have been increasingly large DHF epidemics every two to three years. In recent years, transmission has spread from the urban centers of Phnom Penh and Battambang to smaller towns and villages.

There is a clear need for continued surveillance and increased capacity to deliver effective and appropriate clinic services, health education and control activities in high risk areas. Related to malaria, there is a continuing need for monitoring of drug-resistant malaria, drug-use practices and drug quality, and the development and implementation of interventions to improve the rational use of anti-malarial drugs. Efforts to control and manage DHF should be focused on geographic areas of highest risk, including Phnom Penh and Battambang.

A strategy for addressing tuberculosis, particularly HIV/AIDS-TB co-infection, has been developed with the assistance of the Tuberculosis Coalition for Technical Assistance (TBCTA). This strategy calls for assistance with formulating a national HIV-TB strategy, plan and expenditure framework; regular technical assistance to the National Tuberculosis Program (NTP); strengthening of planning and management skills at the national and provincial levels in communicable disease control; operational research on diagnostic issues and alternative service delivery mechanisms; expansion of the directly observed treatment short-course (DOTS) to the health center level and into communities; and, continued support for IEC and advocacy on TB.

Demand for quality health care. Individuals, families and communities need to be empowered to demand high quality care, change their health seeking behavior, and actively participate in and influence the systems responsible for delivery of their health care services.

IV. STRATEGIC OBJECTIVES AND RESULTS FRAMEWORKS

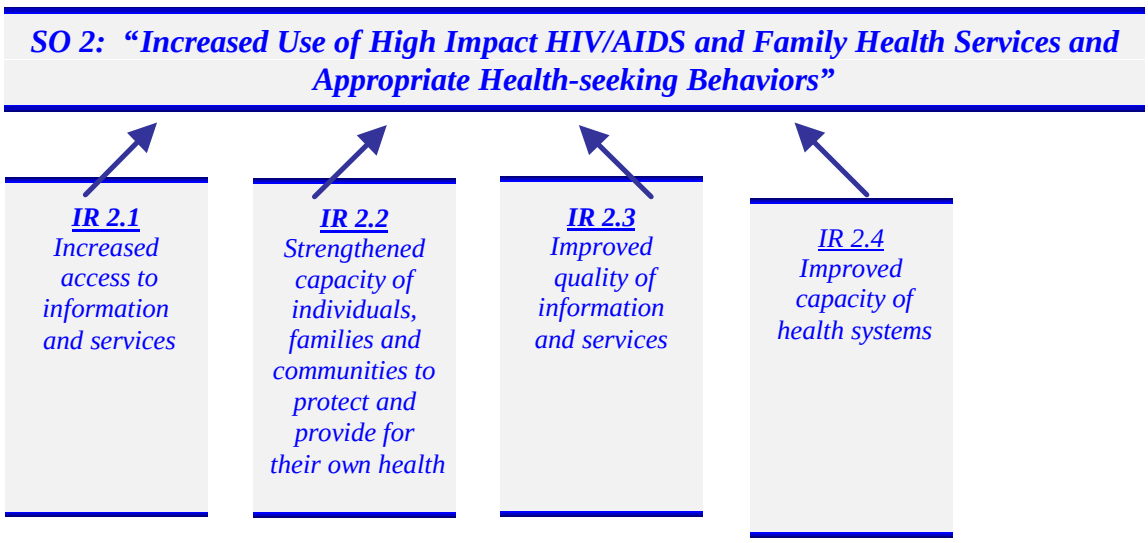
The need for reproductive and child health (RCH) and HIV/AIDS interventions is compelling: Cambodia's maternal, infant and child morbidity and mortality rates are among the highest in the world, and HIV prevalence is alarmingly high and the epidemic has been one of the fastest growing in the world. The incidence of tuberculosis is also the highest in the world outside Sub-Saharan Africa. Malaria is a leading cause of morbidity and mortality. Dengue hemorrhagic fever is the leading cause of death among children aged 1-5 years, and poor health conditions are more than just a health sector problem: household expenditures for health care are a leading cause of landlessness and indebtedness.

The problems are formidable. The capacity of the health system to address these problems is, however, extremely limited. The current public health system is only five years old and not yet fully established. Numerous NGOs and other donors have been contributing to the strengthening of the health system and delivery of health information and services. These efforts are often quite limited in scope and scale, however. Most Cambodians rely on private service providers who have little or no medical knowledge.

Although progress is being made by the Ministry of Health in implementing a national health coverage plan, it will take time to achieve the goal of accessible health services nation-wide. The need to deliver both RCH and HIV/AIDS interventions is urgent and cannot wait for the full development of the health care system. At the same time, interventions cannot be delivered without such a system and will always be constrained by the level and pace of system development.

USAID/Cambodia will therefore proceed on two tracks simultaneously: strengthening the nascent service delivery system, and promoting the delivery of specific, well-targeted, interventions addressing the formidable HIV/AIDS, maternal and child health, and infectious diseases situation in Cambodia.

Strategic objective for population, health and nutrition
USAID Cambodia's strategic objective and intermediate results for population, health and nutrition for the three-year period 2002 to 2005 are:



USAID will address the critical family health problems noted above by strengthening the capacity of the Cambodian health system to provide a basic package of essential health services in predominately rural areas. In this context, "health system" is defined holistically to include the planning, management, human resources, quality assurance and oversight systems in selected provinces and operational districts (OD); OD-level service delivery facilities, plus the supervisory and referral systems to support them; international and local NGOs; commercial and other private sector health care providers; and community-level organizations prepared to help educate, mobilize and serve the needs of health-seeking clients at the grassroots level. Their support is key to the success of this strategy.

An important consideration behind the adoption of an OD-based strategy is the continuing upward trend in the RGC budget for the health sector. RGC per capita outlays in the health sector have doubled over the past three years. If this trend continues, the RGC may eventually be in a position to assume a significant share of the investment required to implement the OD-based portion of the strategy. USAID and other donors in Cambodia are currently making per capita investments of such magnitude in localized areas, but largely through NGOs. The distinctive aspect of USAID's onward strategy is that it would focus a significant portion of its future investment on measures to substantively improve the institutional, managerial and human capacity of the public health system – in cooperation with its international and local non-governmental partners and communities – to provide health information and services. While this approach might produce less evident quantifiable achievements in the short-term versus for example, the various contracting arrangements adopted by some donors, it is likely to produce a more sustainable host country delivery capacity over the medium-to-long term. It should also be noted that the USAID strategy, unlike those of other donors, will not include any salary supplements or other inducements for public sector employees.

Individuals, families and communities will be empowered to demand high quality care, to change their health-seeking behavior, and to actively participate in and influence the systems responsible for delivery of their health care services. An increase in demand for services will increase utilization rates of public sector health care services.

Sectoral Strategies

Through a holistic approach centered on the provincial and OD-level, in addition to high-priority national-level initiatives, USAID will address critical concerns related to HIV/AIDS, RH/MCH and infectious diseases.

In designing its assistance program for the ***HIV/AIDS*** sector, USAID will follow the guidance of Cambodia's National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS (2001-2005). This Plan reflects an important paradigm shift from a vertical, exclusively health-centered and top-down approach to a more holistic development approach that is gender- and community-sensitive. In developing health sector-related interventions to address HIV/AIDS, USAID will ensure consistency with the policies and guidelines of the National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) and the National AIDS Authority (NAA).

Indeed, USAID will seek to broaden this paradigm shift across its entire PHN strategy. This strategy will take advantage of opportunities to improve the technical quality of services and cost-effectiveness through development and delivery of an *integrated* health package at the OD level, ensuring that appropriate links are made between HIV/AIDS and all other health interventions. These efforts would contribute to the identification of effective approaches to service delivery that could be replicated by the RGC and other donors.

USAID will employ a *three-pronged approach* in its response to HIV/AIDS:

- Activities at the *national* level, taking advantage of USAID's and cooperating agencies' (CA) comparative advantage and success in providing technical assistance, condom social marketing, and behavior change communication services targeted at commercial and indirect sex workers, high risk men (including the uniformed services), and other

vulnerable groups such as garment workers and mobile populations. Much of this work will involve taking-to-national-level-scale activities that have demonstrated their effectiveness in reaching high-risk and vulnerable populations.

- Activities at the *provincial* level, and within the context of the holistic OD-based strategy discussed above including:
  - HIV/AIDS prevention activities at the OD level, ensuring that prevention messages and condom supplies are integrated with other reproductive, maternal and other health services.
  - Expansion of voluntary counseling and testing (VCT) and linkage with other testing and curative treatment at the OD level; particular attention will be paid to preventing infection and women of child bearing age and mother-to-child transmission (MTCT) of HIV.
  - Assistance to eventually ensure comprehensive availability of the MPA+ and the hospital-based CPA.
  - Home-based care to offer simple treatment and palliative care for Persons Living with HIV/AIDS (PLWHA), plus social support services for children and families affected by AIDS.
- Continued strong support for *field-based research* on effective approaches to reach key populations with: (1) prevention and care, and (2) surveillance and monitoring of sero-prevalence and sexual behavior.

USAID has been an active and important partner in the battle against HIV/AIDS in Cambodia since 1993. USAID's support, together with that of other donors, for policy change, national information campaigns, targeted interventions with high-risk populations, and critical surveillance and behavioral studies have contributed to heightened HIV awareness, behavior change and reduced prevalence among key populations. Good models of successful interventions with high-risk populations that have been developed should now be scaled up.

Many of the current activities are focused on relatively small segments of the high-risk and at-risk populations such as police and military personnel, factory workers and commercial sex workers. These will be scaled up significantly and expanded to other high-risk populations such as indirect sex workers, migrant workers, truck drivers and other mobile populations.

In addressing the critical ***maternal health*** situation, USAID will support efforts to gradually shift deliveries from traditional birth attendants to trained midwives in selected provinces and ODs. The main focus of this effort will be on capacity building and support to midwives through training in Life Saving Skills (LSS); strengthening the referral system to provide emergency obstetric care; building the capacity of doctors who support and supervise the trained midwives; and, supporting partnerships between midwives and traditional birth attendants (TBA).

In ***reproductive health***, USAID will focus on increasing availability of contraceptive products at the community level through community-based approaches – moving beyond the current health center medical model. Partnerships with private providers of reproductive health services will be further developed and social marketing of contraceptives will be expanded in rural areas. The expansion of voluntary family planning services will address the significant needs and unmet demand for contraceptive products by married couples. IEC efforts will promote the practice of three-year birth intervals2.

The reproductive health needs of adolescents will be addressed through support for the development and expansion of youth-friendly information and services, including emergency contraception. Particular attention will be paid to particularly vulnerable groups of young people, including the growing urban middle class, and garment sector workers. Emphasis will also be placed on improving the health system's capacity to provide post-abortion care and treatment for STDs in targeted provinces and ODs.

USAID will increase access to ***child health*** services by strengthening the capacity of selected ODs to deliver the necessary and appropriate services within the MPA+ package that are directed at addressing critical child health problems. Particular attention will be paid to ARI, diarrhea and malnutrition, including optimal breastfeeding and infant feeding

practices and use of micronutrients, especially Vitamin A. USAID will also work with UNICEF and WHO to support the RGC's pilot testing of Integrated Management of Childhood Illness (IMCI), and scale up that activity in ODs selected for implementation of assistance under this strategy.

Related to ***tuberculosis***, USAID will work in close collaboration with the National Tuberculosis Program (NTP) in developing a national HIV/AIDS-TB strategy and plan, and strengthening capacity at the national, provincial and district levels to provide more effective diagnosis and treatment services. Emphasis will also be placed on identifying and supporting community-based approaches to expanding information dissemination and service provision. These efforts will be carried out in close collaboration with NTP, WHO, Centers for Disease Control (CDC), the Tuberculosis Coalition for Technical Assistance (TBCTA), and selected local partners.

In addressing ***malaria***, USAID will continue to support the RGC's national Roll Back Malaria plan in collaboration with WHO and selected local partners. Particular attention will be paid to addressing issues related to drug-resistant malaria and rational use of anti-malarial drugs.

USAID will also work in collaboration with WHO and local partners in addressing ***dengue*** and will continue to support the RGC's dengue hemorrhagic fever (DHF) program. Efforts will focus on geographic areas of highest risk, including Phnom Penh and Battambang, and will expand and improve surveillance, clinical management, health education, and control activities in other high-risk areas of the country.

Intermediate Results

IR 2.1: *Increased access to information and services*

HIV/AIDS: Documented successes in changing the behavior of high-risk populations demonstrate that Cambodians will act when provided adequate information and services. Most however, lack access to information, voluntary counseling and testing, condoms and STI diagnosis and treatment – resulting in considerable unmet needs, especially among high-risk and mobile populations. Advancing the availability of affordable, effective, high-quality health care and social services is also essential to mitigate the effects of the epidemic on the 72,000 adult women and 97,000 adult men in Cambodia who already are living with or affected by HIV/AIDS.

Reproductive Health/Maternal & Child Health: Inadequate and often inaccurate information, and low access to RH/MCH services underlie the high mortality and morbidity rates. There is a significant unmet need and demand for birth spacing, antenatal/postnatal care, safe delivery, and child health information and services. Access to these services is currently limited as a result of geographic, economic and social barriers.

Infectious Diseases: Increased access to diagnosis and treatment services is essential for controlling the rapid expansion of TB, particularly as linked to HIV/AIDS. Improper use of anti-malarial drugs and the emergence of drug-resistant strains of malaria are threatening efforts to reduce malaria deaths. The spread of DHF from urban centers to smaller towns and villages is creating new challenges in prevention and control.

Key approaches and illustrative activities [SEE: MONITORING & EVALUATION SECTION AND "RESULTS MATRIX" FOR A COMPLETE AND UP-TO-DATE LIST OF RESULTS]

- Improve collaboration among the public, NGO and private sectors
  - *pilot test private sector provision of VCT for HIV/AIDS*
  - *conduct operational research on private sector provision of the directly observed treatment short-course (DOTS) for TB*
  - *develop a private provider network to expand access to contraceptives; train rural retailers to provide non-clinical contraceptives, including emergency contraception*
  - *scale up successful models of midwife-TBA partnership*
  - *strengthen the Cambodian Midwives Association as a vehicle for improving the quality of care, and for developing advocacy and leadership skills in the safe motherhood policy-making process*

- *test the feasibility of contracting selected services to the NGO and private sector*

♦ Integrate information and services
- *link VCT to care and support*
- *link HIV/AIDS and TB diagnosis and treatment*
- *improve access to information and services for prevention of MTCT*

♦ Expand coverage by increasing the number of service delivery points and community outreach
- *expand community-based distribution of contraceptives*
- *expand social marketing of contraceptives in rural areas*
- *test feasibility of expanding social marketing product line to include MCH and vector control products*
- *train garment factory health services personnel to provide contraceptive products and referrals*
- *test and replicate community-based approaches to HIV/AIDS care and support*
- *expand availability of maternal and child health services through health center and NGO outreach workers*
- *support pilot studies on the provision of DOTS through community-based groups*

♦ Broaden services offered by providing integrated MPA+ and selected components of the CPA
- *increase access to VCT and, STD treatment and diagnosis*
- *scale up Life Saving Skills (LSS) training to all midwives in selected ODs*
- *strengthen logistics and information systems to ensure a reliable supply of contraceptives and other essential drugs*
- *train referral hospital staff in voluntary surgical contraception and counseling*
- *support efforts to pilot test and phase-in IMCI efforts to address diarrhea, ARI, measles, malaria, malnutrition and dengue in selected ODs*
- *support DOTS expansion to health centers in selected ODs*

♦ Focus on selected target groups
- *scale up HIV/AIDS targeted interventions to achieve national coverage, and expand coverage to other high-risk groups*

HIV/AIDS: Many Cambodians still lack critical information about what they can do to prevent infection for themselves and their loved ones, as well as the risks of relationships with sweethearts and infected partners. Few women are empowered to insist that their sexual partner wear a condom. Inaccurate knowledge about HIV/AIDS and its transmission contributes to the stigmatization of those infected and affected by HIV/AIDS. Many communities and families are reluctant to provide care for the children of those who have died of AIDS because of fear of infection.

IR 2.2:
Strengthened capacity of individuals, families and communities to protect and provide for their own health

Reproductive Health/Maternal & Child Health: Demand for MCH services from trained providers is low compared to the demand for services from the unregulated, unskilled private sector, and reliance on inappropriate, and often harmful, self-care practices. Whereas latent or unmet demand for contraceptive services is great, individuals' ability to use contraceptives is constrained by an environment that is largely unresponsive to their needs. Although knowledge about some form of contraception is nearly universal, individuals have not been systematically informed about their range of choices, including the pros and cons of different contraceptives, where to obtain services or their options when encountering side effects.

Infectious Diseases: Individuals need to be made aware of the signs and symptoms of TB and the availability of treatment. Communities need to be more actively engaged in efforts to protect themselves from malaria and dengue vectors. Incorrect behaviors and practices (e.g. in dispensing and using anti-malarial drugs) contribute to the spread of drug resistance.

Key approaches and illustrative activities

♦ Make health information more broadly available through mass and print media, community mobilization, and interpersonal communication and counseling.
- *promote an integrated 'package' of messages that will educate individuals, families and communities about appropriate health-seeking behavior*

- *scale up 'sweetheart' condom campaign*
- *promote dual use of condoms, three-year birth interval, use of skilled birth attendants, optimal breastfeeding, use of ORS, immunization, Vitamin A, improved maternal nutrition and TB awareness*
- *conduct intensive health education to promote appropriate behavior among care-givers of children*
- *develop IEC materials which address the needs of adolescents and young adults and make available where large numbers of young people are found*
- *develop IEC messages on TB in collaboration with ODs and village feedback committees (FBC)*

♦ Increase partnerships with non-health organizations and programs
- *involve FBCs, village development committees (VDC) and other appropriate community structures/ mechanisms in efforts to strengthen community-level tolerance and support for Persons Living with HIV/AIDS (PLWHA)*
- *train VDCs, FBCs, shop owners and other influential figures such as monks and nuns in basic family planning, counseling and referral*
- *link with non-health community groups such as VDCs, micro-credit groups, literacy groups, etc. as channels for health promotion*
- *develop joint activities with education and rural development programs, and other partners for vector control*

♦ Raise level of demand for quality services
- *increase the involvement of PLWHA in the full range of program and policy activities*
- *create a demand for tetanus toxoid immunization, iron tablets, postpartum Vitamin A*

IR 2.3:
Improved quality of information and services

HIV/AIDS: Many public providers lack the knowledge and training to provide clients with the information they need to protect themselves and their families from HIV/AIDS. Key services and commodities are often unavailable or available on an erratic basis. Public services and service providers are often unwelcoming to men, single women and youth. Private health care providers such as drug sellers supply expensive, ineffectual and sometimes dangerous remedies as well as misinformation. Increasing the quality of HIV/AIDS prevention and services is essential to ensure that persons in need actually avail themselves of these services and that these services are integrated, effective, culturally appropriate and relevant for Cambodia at this stage of the epidemic.

In the context of improving the quality of curative care at the OD level, USAID will seek opportunities to improve the diagnosis of both HIV and TB, and to treat TB and other opportunistic infections related to AIDS. Referral links will be fostered between health care services that diagnose AIDS via VCT, clinical case definition, or home-based care and social support services. Since care and support services are just beginning to be introduced in Cambodia, efforts will be undertaken to support them through appropriate non-governmental organizations (NGOs).

Reproductive Health/Maternal & Child Health: Except for a handful of health facilities that have received support from international donors and NGOs, the quality of services in both the public and private sectors is generally inadequate. Improving the quality of care in both public and private sectors will increase client satisfaction, expand utilization of services, and result in improved health outcomes.

Infectious Diseases: Proper diagnosis of TB and responses to the link between TB and HIV/AIDS need to be strengthened. Efforts should continue to focus on identifying factors contributing to the emergence and spread of drug-resistant malaria. Health providers need to be trained in correct drug identification and dispensing procedures.

Key approaches and illustrative activities

♦ Improve consistency and accuracy of health promotion messages
- *monitor and refine health promotion messages at all levels*

♦ Health worker training
- *maintain focus on capacity building of midwives and on selected doctors who work with these midwives*
- *provide intensive training in interpersonal counseling to all health care providers*

- *provide competency-based training in IMCI to outreach, health center and referral hospital staff*

♦ Promote quality standards of care in provision of health services
- *integrate HIV/AIDS with TB services: develop national strategy and action plan to address HIV-TB issues; improve diagnosis of both HIV and TB; provide treatment for TB and other opportunistic infections related to AIDS*
- *support operational research on laboratory diagnostic issues related to TB directed at improving the accuracy of diagnosis*
- *support home-based care and social support services through ODs and appropriate NGOs*
- *provide training to public and private sector health care providers in HIV universal precautions*
- *create awareness among TBAs about safe delivery practices, recognition of danger signs and referral to health centers and midwives*
- *institute continuous quality improvement in all health centers and referral hospitals to ensure compliance with standards for clinical management of obstetric, neonatal care and infectious diseases*
- *train private health care providers in the correct use of antibiotics, contraceptive technology updates, appropriate use of anti-malarial medications, etc.; certify trained providers with a seal of high quality*

IR 2.4: *Improved capacity of health systems*

HIV/AIDS: Many of the approaches to HIV/AIDS prevention, care and mitigation are limited in scope and coverage. Better information is needed on effective public and private approaches and how to scale these up in a cost effective manner. Information is also lacking on the spread of the epidemic within the general population and the behavior of certain critical populations. Cambodia's HIV Sentinel Surveillance System (HSS) and Behavioral Surveillance Surveys (BSS), developed largely with USAID funding, are of high quality and have been credited with contributing significantly to effective program planning and a policy environment conducive to AIDS prevention in Cambodia. Assistance for these tools will be expanded by USAID during 2002-2005 to include new target groups, as relevant, and will provide an ongoing basis for HIV/AIDS program planning and priority-setting.

*Reproductive Health/Maternal & Child Health***:** Current public health systems are only five years old. Service delivery is inadequate in many areas. Both public and private sector providers need better skills, higher motivation and greater knowledge. Planning, management and supervisory skills are lacking, resulting in inefficient use of scarce financial and human resources. Accurate data are not routinely collected, analyzed or used for management or oversight purposes.

Infectious Diseases: There is a continuing need to strengthen the capacity of the health systems to plan and manage TB control efforts, particularly as related to HIV-TB co-infection. Continuing surveillance is needed to identify geographic and population "hot spots" of malaria drug resistance, drug use, and drug quality. Surveillance capacity for dengue should continue to focus on geographic areas of highest risk, including Phnom Penh and Battambang, while also expanding and improving surveillance, clinical management, health education, and control activities in other high-risk areas of the country. This approach is consistent with the RGC's national dengue/DHF control plan.

Key approaches and illustrative activities

♦ Strengthen planning and management skills at all levels
- *support the development, with the NAA, of HIV/AIDS policies and action plans of the 12 non-health ministries which comprise the NAA*
- *strengthen the capacity for planning and management of TB control at the national, provincial and OD levels; develop operational work plan and expenditure framework for TB control*
- *work with MoH technical working groups to improve the policy environment, particularly operational policies at the provincial, OD and health center levels (e.g., safe motherhood, midwifery training, IMCI, micronutrients, HIV/AIDS, HIV/AIDS-TB management, communicable disease control, etc.)*
- *strengthen referral linkages between all levels of the health system for emergency obstetric care (EmOC) and other selected CPA interventions*
- *support the implementation of the National Safe Motherhood Workplan which details first aid care in village and home, basic EmOC at health centers, and comprehensive EmOC at referral hospitals*
- *strengthen the contraceptives logistics system through refresher courses, on-the-job training, and facilitative supervision at the field level*

- Improve use of data at operational and management levels
  - *develop a field-based research agenda on critical issues in HIV prevention, care and support*
  - *support the operation and further refinement of the HSS and BSS*
  - *support operations research to improve service delivery management*
  - *conduct baseline drug-resistance surveys to map focal points of malarial drug resistance*
  - *conduct behavioral surveillance to assess how dispensing and use of anti-malarial drugs contribute to the spread of drug resistance*
  - *strengthen DHF laboratory capacity and disease and vector surveillance*
- Transfer program skills and responsibility gradually to host country organizations
  - *strengthen the capacity of public and private sector organizations to deliver effective HIV/AIDS, RCH and infectious diseases services*
  - *strengthen the human and organizational capacity of health service providers*
  - *strengthen the skills of health providers in management, facilitative supervision and use of data*
  - *strengthen the capacity of Cambodian institutions to respond to DHF*
  - *train health providers in the development of hospitalization emergency plans*
  - *increase access to reference material and training on communicable disease control*

Health Systems Strengthening Component

Integrated (holistic) Focus on Health Services at the Provincial and Operational District (OD) Level: The health care system in Cambodia is only five years old, and still in early stages of development. To be effective, health and disease specific interventions must be accompanied by measures to strengthen the health care delivery system, particularly its decentralization at the level of the Operational District.

The health system's development and maturation are fundamental to achieving success in all intervention areas of family and community health, particularly: maternal and child health, infectious diseases, reproductive health and HIV/AIDS prevention and care. Without this, all other interventions are just tinkering around the edges. A number of innovative efforts in health sector reform and policy dialogue between government, donors and implementing agencies are underway. Political commitment to achieving a functioning public health system is increasing and needs to be supported.

To maximize impact and effective leveraging of resources, and minimize management burden, a number of provinces will be selected for intensive focus, in addition to the continuation of selected national-level interventions. Within these provinces, a closely linked and strategic package of interventions should be provided, in tandem with general support to strengthen the health service delivery system, at the Operational District level.

The human resource capacity in health in Cambodia is severely constrained by a number of factors. These include, but are not necessarily limited to, the following: the inadequate size of the workforce relative to the population and needs; the lack of up-to-date training, both basic and post-basic; and the limited financial resources available from government. Capacity building of the public health workforce must go hand in hand with the interventions. Projects in the current portfolio have demonstrated that capacity building, particularly for public sector health staff, requires intensive, hands-on mentoring and coaching from suitably trained local counterparts.

USAID will address the family health problems noted above by strengthening the capacity of the Cambodian health system to provide a basic package of essential health services (MPA+ and CPA) in predominately rural areas. For the purposes of this RFA, "health system" is defined holistically to include the existing planning, management and oversight systems in selected provinces and operational districts; OD-level service delivery

facilities, plus the supervisory and referral systems to support them; international and local NGOs; commercial and other private sector health care providers; and community level organizations prepared to help educate, mobilize and serve the needs of health-seeking clients at the grassroots level. The latter support mechanisms are to the success of the strategy.

Geographic Coverage:

Key provinces and ODs have been identified as part of the design phase of the strategy. The number and location of these ODs (population between 100,000-300,000 each) have been determined by: (1) the amount of funds available to USAID for implementation of this portion of the strategy (WHO and NGO data indicate that a holistic approach to health service improvement at the OD level can be expected to cost $700,000 -$1,000,000 per OD per year); and (2) the application of rigorous activity and site selection criteria developed with the RGC. These criteria include five major considerations: epidemiologic, demographic, geographic, organizational institutional/human resources (public-private-NGO-donor), and behavioral (high risk and health seeking). For example, consideration has been given to population size, HIV prevalence, the existence of a functioning health services infrastructure, the presence of other international donors, and the effectiveness and readiness of provincial and OD-level leadership to work constructively with USAID and its partners. The effectiveness of implementation of health programs by provincial-level authorities has been further assessed by such proxy measures as the proportion of central funds passed directly to the provinces to support health facilities, and/or the coverage of the provincial EPI programs.

A key consideration for the adoption of an OD-based strategy is the continuing upward trend in the RGC budget for the health sector. As noted above, RGC per capita outlays in the health sector have doubled over the past three years (from $1.00 per capita in 1998 to $2.00 in 2000). If this trend continues, the RGC may eventually be in a position to assume a significant share of the investment required to implement the OD-based portion of the USAID strategy. USAID and other donors in Cambodia are currently making per capita investments of such magnitude in localized areas, but largely through NGOs. A distinctive aspect of USAID's integrated strategy is that it will focus a significant portion of its future investment in measures that will substantively improve the institutional, managerial and human capacity of the public health system - in cooperation with its non-government partners and communities - to provide health care services. While this approach might produce less evident quantifiable achievements in the short term *vs.* for example, various contracting experiments adopted by some donors, it is likely to produce a more sustainable host country delivery capacity over the medium-to-long term. It should also be noted that the USAID strategy, unlike those of other donors, will not include any salary supplements or other inducements for public sector employees.

<u>The Future</u>:

Under the new PHN strategy for FY2002-2005, the strengths of the current health [PHN] program will be supported as resources permit. Activities will be streamlined to reduce organizational and programmatic redundancies, make better use of inherent synergies and opportunities, and provide a strategic geographical focus on priority provinces and operational districts. Maintaining an information/service delivery focus, bolstered by a health systems strengthening component, will effectively maximize the impact of USG investments.

<u>Decentralization</u>:

Decentralization is a key reform issue for all sectors, including the health sector. The socio-cultural-economic and political climate provides a unique opportunity for USAID to assist the Royal Government of Cambodia to

advance the decentralization process now underway. The challenge for RGC, with its development partners, will be how to make decentralization work to appropriately support development efforts across all sectors. The Ministry of Health is committed to strengthening institutional, management, and technical capabilities of provincial and operational district health providers, offices, facilities and systems. In the health sector, RGC and its development partners will need to identify and strengthen provincial/operational district level mechanisms and management systems/tools so that decision-making can be more efficient and effective.

V. GENERAL GUIDANCE

To date, USAID-assisted activities in population, health and nutrition have been implemented in a somewhat diffused manner over many of Cambodia's twenty-four provinces. For 2002–2005, USAID/C and its partner organizations are considering limiting its geographic coverage for health services to selected provinces and operational districts. Once these operational districts have demonstrated an ability to provide quality health services and information regularly, routinely, and on demand through the effective utilization and coordination of district resources and revenues, expansion to additional provinces and districts will be considered.

While a variety of activities have been tried in these districts over the years, it is important that any new options be carefully considered in regard to the provision of services, local conditions, effort involved, the effect on patient/client relations, and cost effectiveness. Thus, the Applicant(s) should carefully review the current program and consider new approaches or more flexible and opportunistic interventions to help strengthen the health system and its attendant health information and service delivery mechanisms. It will be especially important for the Applicant(s) to describe illustrative system approaches/strategies and interventions that are simple, sustainable, workable, amenable to changing course/alteration, and are situation-specific within the context of Cambodia and that could be sustainable once USAID assistance ends a few years hence.

Given the site selection criteria and the administrative, structural, managerial and geographical considerations within the Cambodian context, Applicants are expected to synthesize the various sectoral interventions [technical components and their cross cutting themes] into a 3-year Strategic Plan and Annual Plan for the first year. Use the attached documents (attachments), other key documents of your choosing, or your experience in Cambodia to complete this task. Justify how you/partner(s) would achieve the intended results. Feel free to suggest other interventions or approaches that you believe may strengthen and/or focus the Health Systems Strengthening work within the context of Cambodia.

The following broad, general questions/issues should be considered in developing applications:

1. Based on your experience elsewhere and your knowledge of Cambodia, is it appropriate to concentrate effort and resources on a limited number of priority provinces and operational districts or have more model projects or demonstration areas? Are there other approaches that should be considered?

2. How would your Plans complement that of other donors working in health systems strengthening [e.g., other donor support for infrastructure/renovation, equipment, human resources training/development, service delivery of related health services in other operational districts]?

3. Compare the costs of fixed priority districts with other activities/programs given issues of replicability and sustainability as well as RGC commitment and budgetary requirements to continue and/or expand without heavy reliance on donor assistance.

4. How would your Plans institutionalize human resource capacity and systems within MOH and the National Programs to strengthen sustainability [organizational, programmatic and financial]?

5. How should the health systems strengthening component target scarce resources in order to maximize capacity building to strengthen the institutionalization of human resource capabilities and systems [planning, management and oversight systems] within the health system, particularly at provincial and OD levels, to ensure capacity building and sustainability (organizational, programmatic and financial)? Which interventions, where, and why?

6. How might complementarity, synergy, cost-sharing/cost-recovery, and other linkages with other programs and sectors be achieved, especially at operational district and community levels?

7. How can flexibility of response or intervention be built into the component design, given the possibility of demographic/epidemiologic change, policy/regulatory changes, or an unstable political environment?

8. Are there policy or regulatory reforms that, if made, would greatly assist current or proposed interventions?

9. How will decentralization affect the choice to focus on a limited number of provinces or operational districts and interventions?

The following, <u>specific questions/issues</u> should also be considered in developing applications:

1. Recognizing that a systems approach is called for, describe how you would address the essential elements of district health services (Health Centers, Health Center outreach, Referral Hospital and the Operational District Health Team) and the referral mechanisms, and linkages between them.

2. What kinds of technical assistance will be required for a systems approach?

3. How kinds of training would you include, through both formal and informal mechanisms, for HC, RH and DHMT staff to improve clinical, counseling/interpersonal, and managerial skills?

4. What kinds of linkages are there, or should be put in place, to connect the Health Center with communities? Within communities to provide an essential mechanism for improving HC-villager relations, mobilizing the community for outreach sessions and promoting health practices and utilization of preventive services?

5. Beyond the five site selection criteria, what additional criteria or data would you use to determine geographical site selection of focus provinces and operational districts? Why?

6. Given the general lack of human resource capacities in Cambodia, what kind of plans, policies and resource allocation for local staff development, and deployment of a critical mass of professional staff (both international and local) at the field level with phased in devolution of authority and responsibility to them would you recommend?

Elements to consider are: (a) activities and/or interventions and geographic locality; (b) role, type and number of partners required both in terms of implementing partners and provincial/district level in Cambodia; (c) cost effectiveness of alternative interventions and partnerships; (d) local organization capacity building and long term competency and viability; and (e) appropriate performance indicators.

VI. MONITORING AND EVALUATION

The health environment in Cambodia is a dynamic environment where diffusion of innovations is rapid and where strategic planning expertise and a commitment to collaborative alliances among public and private partners have the potential to contribute significantly to improvements in the health infrastructure and health outcomes. Given the epidemiological, demographic, behavioral, geographic, organizational, and institutional profile of Cambodia, the developmental nature of the interventions currently being implemented, and the changing political and policy environment, the ability to efficiently modify and redirect programs based on quality program evaluation, surveillance, and research data will be a decided advantage.

Currently, plans are underway to augment the proposed 3-year PHN Strategy with a focused research agenda. This agenda includes, but is not limited to, operations research, comprehensive M&E by each implementing partner, routine cross-sectional surveillance of HIV infection, as well as at-risk and preventive behaviors, periodic STI prevalence surveys, and the probable addition of longitudinal surveillance that would establish sentinel sites in the PHN strategy's target districts. In addition, data from the first Cambodia Demographic and Health (DHS) survey conducted in 2000 are available and the second DHS is scheduled for 2004/05. Other national surveys have been conducted, such as the 2001 National Nutrition Survey, and district, provincial and national level health statistics are routinely collected by the Ministry of Health through the National Health Information System. Additional service statistics are also routinely collected by the Cooperating Agencies. Other sources of qualitative data will also be developed to enrich the explanatory strength of the more traditional health indicators.

Adhering to USAID's Results Framework and M&E requirements, Applicants should propose an illustrative monitoring and evaluation plan for assessing the potential inputs, processes, outputs, outcomes and impact for the most relevant IR or IRs for health systems strengthening under the 3-year PHN Strategy. Once the award is made and the Applicant has established a presence in Cambodia, the proposed illustrative M&E plan will be modified and more fully developed in collaboration with the other members of the implementing partnership. In other words, the successful Applicant(s), in coordination with USAID/C, its service delivery Cooperating Agencies and their local partners, RGC and other development partners, will develop a detailed M&E plan when the multi-year strategy and annual workplan/s are being finalized.

The following Figure presents a set of results or objectives that the current USAID partners have defined to help articulate the desired achievements for the 3-year strategy period in relation to the four Intermediate Results.

RESULTS MATRIX

By the end of three years:

IR 1 ***Increased access to information and services***	**IR 2** ***Strengthened capacity of individuals, families and communities to protect and provide for their own health***	**IR 3** ***Improved quality of information and services***	
FAMILY HEALTH			
1.1 Each health center in selected Ods will be supported in the implementation of the MPA, and MPA+ where appropriate 1.2 Referral systems from the community to the HC and to the referral hospital will be strengthened and will include functioning emergency obstetric care where feasible 1.3 The outreach system in selected Ods will be functioning effectively with full participation from communities 1.4 Social marketing distribution systems strengthened and number of outlets expanded in rural areas 1.5 High quality services will be strengthened and expanded, and efforts made to make them affordable in the NGO and private sectors to complement MoH goals	2.1 Knowledge, attitudes, beliefs and practices about key family health, birth spacing and HIV/AIDS services will be improved among adolescents, young adult men and women, married couples, care-takers of children, and high risk groups in selected Ods 2.2 Individuals and families will understand their right to receive high quality services and will seek these services where available 2.3 Communities will be mobilized to actively participate in promoting and improving their health	3.1 The quality of care will be improved in all health centers in focus ODs 3.2 Models for improving the quality of RH/MCH services in the private sector will be tested and scaled up 3.3 A system of continuous quality improvement will be instituted in all HCs and referral hospitals in focus ODs 3.4 Health worker skills in appropriate case management of ARI and diarrheal diseases will be strengthened in all focus ODs; skills in IMCI will be improved in selected pilot and scale-up ODs 3.5 Midwifery and life saving skills of midwives will be improved in all HCs 3.6 Inter-personal communication skills, including counseling, in RH/MCH will be improved among all HC health providers in focus ODs	4.1 F healt and impr 4.2 C the d will level 4.3 M of da instit 4.4 F FP c the n OD p in fo

IR 1 ***Increased access to information and services***	**IR 2** ***Strengthened capacity of individuals, families and communities to protect and provide for their own health***	**IR 3** ***Improved quality of information and services***	
HIV/AIDS			
1.6 HIV/AIDS/STI prevention information and services-in cluding peer education, outreach services, condom promotion –will be more broadly available, especially for vulnerable groups 1.7 The number of voluntary testing and counseling sites will be increased from the current seven to at least one in each targeted operational district 1.8 Approaches/models of information and care systems including institutional and community-based care and support for those infected and affected by HIV/AIDS will be tested, developed and expanded to targeted operational districts, and accessible to PLWHA 1.9 Prevention of mother-to-child transmission of HIV /AIDS services developed and accessible to pregnant women in selected operational districts 1.10 Reproductive health information and services--including particularly, but not exclusively HIV/AIDS--will be available to major work-based populations such as garment factory workers and adolescent populations	2.4 A decline in high risk behaviors among key populations 2.5 Increased capacity to make informed choice of public or private services in target districts and provinces 2.6 More effective use of personal resources for health care 2.7 Greater community tolerance, involvement with and support for those infected or affected by HIV/AIDS	3.7 Specialized services for target populations will be available nationwide 3.8 HIV/AIDS related services will be integrated into ongoing health services in focus ODs - high quality voluntary testing and counseling services will be linked to care and treatment 3.9 HIV/AIDS counseling, communication and advocacy skills of health providers will be improved at all levels of health care in focus ODs	4.5 M the p 4.6 I capa 4.7 I guide 4.8 I inclu know areas 4.9 I progr of su

1.11 Increased access to vector control, prevention and appropriate treatment measures in areas endemic with malaria and dengue 1.12 Support DOTS expansion to HCs in selected ODs/provinces 1.13 Continued support for IEC and Advocacy, through USAID partners, focused on community-based development of messages and materials on TB 1.14 Support the development of guidelines and models for linkages between HIV/AIDS and TB services	2.8 Communities will be mobilized to undertake vector control, prevention and treatment measures 2.9 Communities will understand the effect of using inappropriate anti-malarial drugs 2.10 Increased utilization and appropriate use of community DOTS services 2.11 Promotion of early case detection	3.10 Public and private sector providers will dispense quality anti-malarial drugs 3.11 Utilization of standard clinical management practices for treatment of infectious diseases will be increased among health providers in focus ODs 3.12 Support will be provided to CDC/RIT operational research project(s) studying laboratory diagnostic issues related to the high sputum smear-positive rate among TB suspects and the high false positive rate of diagnostic smears 3.13 Support will be provided to operational research on the feasibility of DOTS by private health providers in collaboration with WHO, CDC, KNCV, in-country partners and local NGOs, building on FHI's work in Phnom Penh 3.14 Support will be provided to studies on community-based DOTS by groups such as Village Health Volunteers, TBAs, FBC members, in collaboration with WHO, CDC, AID partners and NGOs	4 r e 4 a (c 4 c 4 a f p 4 H
ENABLING ENVIRONMENT			
1.15 NGOs strengthened to become active collaborators in public/private partnerships 1.16 Multi-sectoral health policy environment strengthened and the implementation of MOH and National Program strategies and operational plans implemented across selected line ministries, (horizontally across ministries and vertically at every administrative level). 1.17 (HIV) Multi-sectoral HIV/AIDS policy environment strengthened and support	2.12 Greater capacity & increased mobilization of individuals, families and communicates to participate in the health care system 2.13 NGO & network capacity strengthened to effect policy change, increased resource flows, and to enable them to represent community interests at policy forums, resulting in increased participation in the health care system 2.14 (HIV) Greater capacity & increased	3.15 Increase use of evidence based information to improve the quality of services. 3.16 Strengthen capacity in policy & guideline formulation for the implementation of appropriate standards of care. 3.17 Improved regulatory mechanisms and environment for the private sector to increase the quality of private sector provision of health services. 3.18 (HIV) Increased PWA participation in developing or improving policies, guidelines,	4 (a i 4 p &

provided for the development and implementation of strategic and operational plans by selected line ministries (with an emphasis on stigma reduction, promotion of human rights, Greater Involvement of People living with AIDS.	mobilization of civil society organizations (PWA, SOS & FBOs) to participate in the HIV response focused on overcoming silence, fear, stigma and discrimination.	and protocols for the implementation of standards for quality of information, care and support for PWA's, orphans and vulnerable children.	

VII. SUBSTANTIAL INVOLVEMENT UNDERSTANDINGS

USAID will be substantially involved during performance of this Award as follows:

a. Approval of three-year strategic plan and annual work plans;

b. Designation of key positions and approval of key personnel;

c. USAID approval of monitoring and evaluation plans, and USAID involvement in monitoring progress toward the achieve during the course of the cooperative agreement.

d. Approval of sub-grants/sub-awards.

SECTION D

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

CERTIFICATIONS, ASSURANCES, AND OTHER STATEMENTS OF APPLICANTS [1][2]

PART I - CERTIFICATIONS AND ASSURANCES

1. ASSURANCE OF COMPLIANCE WITH LAWS AND REGULATIONS GOVERNING NON-DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS

(a) The recipient hereby assures that no person in the United States shall, on the bases set forth below, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under, any program or activity receiving financial assistance from USAID, and that with respect to the grant for which application is being made, it will comply with the requirements of:

(1) Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352, 42 U.S.C. 2000-d), which prohibits discrimination on the basis of race, color or national origin, in programs and activities receiving Federal financial assistance;

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), which prohibits discrimination on the basis of handicap in programs and activities receiving Federal financial assistance;

(3) The Age Discrimination Act of 1975, as amended (Pub. L. 95-478), which prohibits discrimination based on age in the delivery of services and benefits supported with Federal funds;

(4) Title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.), which prohibits discrimination on the basis of sex in education programs and activities receiving Federal financial assistance (whether or not the programs or activities are offered or sponsored by an educational institution); and

(5) USAID regulations implementing the above nondiscrimination laws, set forth in Chapter II of Title 22 of the Code of Federal Regulations.

(b) If the recipient is an institution of higher education, the Assurances given herein extend to admission practices and to all other practices relating to the treatment of students or clients of the institution, or relating to the opportunity to participate in the provision of services or other benefits to such individuals, and shall be applicable to the entire institution unless the recipient establishes to the satisfaction of the USAID Administrator that the institution's practices in designated parts or programs of the institution will in no way affect its practices in the program of the institution for which financial assistance is sought, or the beneficiaries of, or participants in, such programs.

(c) This assurance is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof to the recipient by the Agency, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

(a) Instructions for Certification

(1) By signing and/or submitting this application or grant, the recipient is providing the certification set out below.

(2) The certification set out below is a material representation of fact upon which reliance was placed when the agency determined to award the grant. If it is later determined that the recipient knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

(3) For recipients other than individuals, Alternate I applies.

(4) For recipients who are individuals, Alternate II applies.

(b) Certification Regarding Drug-Free Workplace Requirements

Alternate I

(1) The recipient certifies that it will provide a drug-free workplace by:

(A) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the applicant's/grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(B) Establishing a drug-free awareness program to inform employees about--

1. The dangers of drug abuse in the workplace;

2. The recipient's policy of maintaining a drug-free workplace;

3. Any available drug counseling, rehabilitation, and employee assistance programs; and

4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(C) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (b)(1)(A);

(D) Notifying the employee in the statement required by paragraph (b)(1)(A) that, as a condition of employment under the grant, the employee will--

1. Abide by the terms of the statement; and

2. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(E) Notifying the agency within ten days after receiving notice under subparagraph (b)(1)(D)1. from an employee or otherwise receiving actual notice of such conviction;

(F) Taking one of the following actions, within 30 days of receiving notice under subparagraph (b)(1)(D)2., with respect to any employee who is so convicted--

1. Taking appropriate personnel action against such an employee, up to and including termination; or

2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(G) Making a good faith effort to continue to maintain a drug- free workplace through implementation of paragraphs (b)(1)(A), (b)(1)(B), (b)(1)(C), (b)(1)(D), (b)(1)(E) and (b)(1)(F).

(2) The recipient shall insert in the space provided below the site(s) for the performance of work done in connection with the specific grant:

Place of Performance (Street address, city, county, state, zip code)

_____

_____

_____

_____

Alternate II

The recipient certifies that, as a condition of the grant, he or she will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the grant.

3. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS -- PRIMARY COVERED TRANSACTIONS [3]

(a) Instructions for Certification

1. By signing and submitting this proposal, the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the department or agency to whom this proposal is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meaning set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. [4] You may contact the department or agency to which this proposal is being submitted for assistance in obtaining a copy of those regulations.

6. The prospective primary participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is

debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," [5] provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the methods and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealing.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

(b) Certification Regarding Debarment, Suspension, and Other Responsibility Matters--Primary Covered Transactions

(1) The prospective primary participant certifies to the best of its knowledge and belief, the it and its principals:

(A) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(B) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(C) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(B) of this certification;

(D) Have not within a three-year period proceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

(2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

4. CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, United States Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that: If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

5. Prohibition on Assistance to Drug Traffickers for Covered Countries and Individuala (ADS 206)

USAID reserves the right to terminate this [Agreement/Contract], to demand a refund or take other appropriate measures if the [Grantee/ Contractor] is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140. The undersigned shall review USAID ADS 206 to determine if any certification are required for Key Individuals or Covered Participants.

If there are COVERED PARTICIPANTS: USAID reserves the right to terminate assistance to, or take or take other appropriate measures with respect to, any participant approved by USAID who is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

6. CERTIFICATION OF RECIPIENT

The recipient certifies that it has reviewed and is familiar with the proposed grant format and the regulations applicable thereto, and that it agrees to comply with all such regulations, except as noted below (use a continuation page as necessary):

_____

_____

_____

_____

_____

Solicitation No. _____

Application/Proposal No. _____

Date of Application/Proposal _____

Name of Recipient _____

Typed Name and Title _____

_____

Signature _____ Date _____

[1] FORMATS: Rev. 06/16/97 (ADS 303.6, E303.5.6a) [2] When these Certifications, Assurances, and Other Statements of Recipient are used for cooperative agreements, the term "Grant" means "Cooperative Agreement". [3] The recipient must obtain from each identified subgrantee and (sub)contractor, and submit with its application/proposal, the Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Transactions, set forth in Attachment A hereto. The recipient should reproduce additional copies as necessary. [4] See ADS Chapter E303.5.6a, 22 CFR 208, Annex1, App A. [5] For USAID, this clause is entitled "Debarment, Suspension, Ineligibility, and Voluntary Exclusion (March 1989)" and is set forth in the grant standard provision entitled "Debarment, Suspension, and Related Matters" if the recipient is a U.S. nongovernmental organization, or in the grant standard provision entitled "Debarment, Suspension, and Other Responsibility Matters" if the recipient is a non-U.S. nongovernmental organization.

PART II - OTHER STATEMENTS OF RECIPIENT

1. AUTHORIZED INDIVIDUALS

The recipient represents that the following persons are authorized to negotiate on its behalf with the Government and to bind the recipient in connection with this application or grant:

Name Title Telephone No. Facsimile No. Email Address

_____

_____

_____

2. TAXPAYER IDENTIFICATION NUMBER (TIN)

If the recipient is a U.S. organization, or a foreign organization which has income effectively connected with the conduct of activities in the U.S. or has an office or a place of business or a fiscal paying agent in the U.S., please indicate the recipient's TIN:

TIN: _____

3. CONTRACTOR IDENTIFICATION NUMBER - DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER

(a) In the space provided at the end of this provision, the recipient should supply the Data Universal Numbering System (DUNS) number applicable to that name and address. Recipients should take care to report the the number that identifies the recipient's name and address exactly as stated in the proposal.

(b) The DUNS is a 9-digit number assigned by Dun and Bradstreet Information Services. If the recipient does not have a DUNS number, the recipient should call Dun and Bradstreet directly at 1-800-333-0505. A DUNS number will be provided immediately by telephone at no charge to the recipient. The recipient should be prepared to provide the following information:

(1) Recipient's name.
(2) Recipient'saddress.
(3) Recipient's telephone number.
(4) Line of business.
(5) Chief executive officer/key manager.
(6) Date the organization was started.
(7) Number of people employed by the recipient.
(8) Company affiliation.

(c) Recipients located outside the United States may obtain the location and phone number of the local Dun and Bradstreet Information Services office from the Internet Home Page at http://www.dbisna.com/dbis/customer/custlist.htm. If an offeror is unable to locate a local service center, it may send an e-mail to Dun and Bradstreet at globalinfo@dbisma.com.

The DUNS system is distinct from the Federal Taxpayer Identification Number (TIN) system.

DUNS: _____

4. LETTER OF CREDIT (LOC) NUMBER

If the recipient has an existing Letter of Credit (LOC) with USAID, please indicate the LOC number:

LOC: _____

5. PROCUREMENT INFORMATION

(a) Applicability. This applies to the procurement of goods and services planned by the recipient (i.e., contracts, purchase orders, etc.) from a supplier of goods or services for the direct use or benefit of the recipient in conducting the program supported by the grant, and not to assistance provided by the recipient (i.e., a subgrant or subagreement) to a subgrantee or subrecipient in support of the subgrantee's or subrecipient's program. Provision by the recipient of the requested information does not, in and of itself, constitute USAID approval.

(b) Amount of Procurement. Please indicate the total estimated dollar amount of goods and services which the recipient plans to purchase under the grant:

$_____

(c) Nonexpendable Property. If the recipient plans to purchase nonexpendable equipment which would require the approval of the Agreement Officer, please indicate below (using a continuation page, as necessary) the types, quantities of each, and estimated unit costs. Nonexpendable equipment for which the Agreement Officer's approval to purchase is required is any article of nonexpendable tangible personal property charged directly to the grant, having a useful life of more than one year and an acquisition cost of $5,000 or more per unit.

TYPE/DESCRIPTION(Generic)	QUANTITY	ESTIMATED UNIT COST

(d) Source, Origin, and Componentry of Goods. If the recipient plans to purchase any goods/commodities which are not of U.S. source and/or U.S. origin, and/or does not contain at least 50% componententry which are not at least 50% U.S. source and origin, please indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, and probable source and/or origin, to include the probable source and/or origin of the components if less than 50% U.S. components will be contained in the commodity. "Source" means the country from which a commodity is shipped to the cooperating country or the cooperating country itself if the commodity is located therein at the time of purchase. However, where a commodity is shipped from a free port or bonded warehouse in the form in which received therein, "source" means the country from which the commodity was shipped to the free port or bonded warehouse. Any commodity whose source is a non-Free World country is ineligible for USAID financing. The "origin" of a commodity is the country or area in which a commodity is mined, grown, or produced. A commodity is produced when, through manufacturing, processing, or substantial and major assembling of components, a commercially recognized new commodity results, which is substantially different in basic characteristics or in purpose or utility from its components. Merely packaging various items together for a particular procurement or relabeling items does not constitute production of a commodity. Any commodity whose origin is a non-Free World country is ineligible for USAID financing. "Components" are the goods which go directly into the production of a produced commodity. Any component from a non-Free World country makes the commodity ineligible for USAID financing.

TYPE/DESCRIPTION	QUANTITY	ESTIMATED	GOODS	PROBABLE	GOODS PROBABLE

(Generic) UNIT COST COMPONENTS SOURCE COMPONENTS ORIGIN

(e) Restricted Goods. If the recipient plans to purchase any restricted goods, please indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, intended use, and probable source and/or origin. Restricted goods are Agricultural Commodities, Motor Vehicles, Pharmaceuticals, Pesticides, Rubber Compounding Chemicals and Plasticizers, Used Equipment, U.S. Government-Owned Excess Property, and Fertilizer.

TYPE/DESCRIPTION (Generic) QUANTITY ESTIMATED UNIT COST PROBABLE SOURCE PROBABLE ORIGIN INTENDED USE

(f) Supplier Nationality. If the recipient plans to purchase any goods or services from suppliers of goods and services whose nationality is not in the U.S., please indicate below (using a continuation page, as necessary) the types and quantities of each good or service, estimated costs of each, probable nationality of each non-U.S. supplier of each good or service, and the rationale for purchasing from a non-U.S. supplier. Any supplier whose nationality is a non-Free World country is ineligible for USAID financing.

TYPE/DESCRIPTION (Generic) QUANTITY ESTIMATED UNIT COST PROBABLE SLUPPIER (Non-US Only) NATIONALITY RATIONALE for NON-US

(g) Proposed Disposition. If the recipient plans to purchase any nonexpendable equipment with a unit acquisition cost of $5,000 or more, please indicate below (using a continuation page, as necessary) the proposed disposition of each such item. Generally, the recipient may either retain the property for other uses and make compensation to USAID (computed by applying the percentage of federal participation in the cost of the original program to the current fair market value of the property), or sell the property and reimburse USAID an amount computed by applying to the sales proceeds the percentage of federal participation in the cost of the original program (except that the recipient may deduct from the federal share $500 or 10% of the proceeds, whichever is greater, for selling and handling expenses), or donate the property to a host country institution, or otherwise dispose of the property as instructed by USAID.

TYPE/DESCRIPTION(Generic) QUANTITY ESTIMATED UNIT COST PROPOSED DISPOSITION

6. PAST PERFORMANCE REFERENCES

On a continuation page, please provide a list of the ten most recent U.S. Government and/or privately-funded contracts, grants, cooperative agreements, etc., and the name, address, and telephone number of the Contract/Agreement Officer or other contact person.

7. TYPE OF ORGANIZATION

The recipient, by checking the applicable box, represents that -

(a) If the recipient is a U.S. entity, it operates as [ ] a corporation incorporated under the laws of the State of_____, [ ] an individual, [ ] a partnership, [ ] a nongovernmental nonprofit organization, [ ] a state or loc al governmental organization, [ ] a private college or university, [ ] a public college or university, [ ] an international organization, or [ ] a joint venture; or

(b) If the recipient is a non-U.S. entity, it operates as [ ] a corporation organized under the laws of _____ (country), [ ] an individual, [ ] a partnership, [ ] a nongovernmental nonprofit organization, [ ] a nongovernmental educational institution, [ ] a governmental organization, [ ] an international organization, or [ ] a joint venture.

8. ESTIMATED COSTS OF COMMUNICATIONS PRODUCTS

The following are the estimate(s) of the cost of each separate communications product (i.e., any printed material [other than non- color photocopy material], photographic services, or video production services) which is anticipated under the grant. Each estimate must include all the costs associated with preparation and execution of the product. Use a continuation page as necessary.

Attachment A

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND V OLUNTARY EXCLUSION LOWER TIER COVERED TRANSACTIONS

(a) Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," ineligible, "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, has the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. 1/ You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier covered Transaction," 2/ without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non procurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

(b) Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Solicitation No. _____

Application/Proposal No. _____

Date of Application/Proposal _____

Name of Applicant/Subgrantee _____

Typed Name and Title _____

_____

Signature _____

1/ See ADS Chapter 303, 22 CFR 208.

2/ For USAID, this clause is entitled "Debarment, Suspension, Ineligibility, and Voluntary Exclusion (March 1989)" and is set forth in the USAID grant standard provision for U.S. nongovernmental organizations entitled "Debarment, Suspension, and Related Matters" (see ADS Chapter 303), or in the USAID grant standard provision for non-U.S. nongovernmental organizations entitled "Debarment, Suspension, and Other Responsibility Matters" (see ADS Chapter 303).

KEY INDIVIDUAL CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

I hereby certify that within the last ten years:

1. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.

2. I am not and have not been an illicit trafficker in any such drug or controlled substance.

3. I am not and have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

Signature: _____

Date: _____

Name: _____

Title/Position: _____

Organization: _____

Address: _____

_____

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140, Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that key individuals of organizations must sign this Certification.

2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

PARTICIPANT CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

1. I hereby certify that within the last ten years:

a. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.

b. I am not and have not been an illicit trafficker in any such drug or controlled substance.

c. I am not or have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

2. I understand that USAID may terminate my training if it is determined that I engaged in the above conduct during the last ten years or during my USAID training.

Signature: _____

Name: _____

Date: _____

Address: _____

_____

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140,Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that certain participants must sign this Certification.

2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

FORMATS: Rev. 06/16/97 (ADS 303.6, E303.5.6a) When these Certifications, Assurances, and Other Statements of Recipient are used for cooperative agreements, the term "Grant" means "Cooperative Agreement". The recipient must obtain from each identified subgrantee and (sub)contractor, and submit with its application/proposal, the Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Transactions, set forth in Attachment A hereto. The recipient should reproduce additional copies as necessary. See ADS Chapter E303.5.6a, 22 CFR 208, Annex1, App A. For USAID, this clause is entitled "Debarment, Suspension, Ineligibility, and Voluntary Exclusion (March 1989)" and is set forth in the grant standard provision entitled "Debarment, Suspension, and Related Matters" if the recipient is a U.S. nongovernmental organization, or in the grant standard provision entitled "Debarment, Suspension, and Other Responsibility Matters" if the recipient is a non-U.S. nongovernmental organization.

SECTION E: PROGRAM ATTACHMENTS

ATTACHMENT 1: GEOGRAPHICAL FOCUS
ATTACHMENT 2: USAID TERMINOLOGY

ATTACHMENT 1: GEOGRAPHICAL FOCUS

Focussed Provinces	**Selected Operational Districts [ODs]**
Bantey Meanchey	Monkul Borei Poipet Thmor Pourk
Battambang	Battambang Mong Russei Sampov Luon Thmor Koul
Koh Kong	Smach Meanchey Sre Ambel
Kratie	Chhlong Kratie
Pursat	Bakan Sampov Meas
Siem Reap	Kralach Siem Reap
Sihanoukville	**Sihanoukville**

Note: In the above 16 ODs in 7 provinces, our coverage will be comprehensive, i.e. MCH, HIV, TB, Malaria. Battambang, Koh Kong, Kratie, Pursat and Sihanoukville will be full provincial coverage because we are going to cover all the ODs in these provinces. In the other two provinces, it is partial coverage. For example, Bantey Meanchey has 4 ODs but we are covering only 3 ODs and in Siem Reap, we are covering only 3 ODs, though there are 3 ODs in the provinces.

Takeo, Kampot, Kampong Cham will have limited sector coverage in selected ODs.

Takeo has 5 ODs but we will cover only 2 ODs for reproductive health and home based care for AIDS patients.

Kampot has 4 ODs but we will cover only 2 ODs with only reproductive health activities.

Kampong Cham has 10 ODs but we will cover only 1 OD with reproductive health activities.

ATTACHMENT 2: USAID Terminology

Strategic Framework (or) Results Framework

A narrative statement or graphical representation of the development hypotheses indicating the results and their causal relationships and underlying assumptions necessary for achieving a strategic objective(s). The framework also establishes an organizing basis for measuring, analyzing, and reporting on the results attendant to achieving the strategic objective.

Strategic Objective/Intermediate Results
Strategic Objective (SO)

The most ambitious result [intended measurable change] that a USAID operation unit, along with its partners, can materially affect and for which it is willing to be held responsible. It forms the standard by which the operating unit is willing to be judged in terms of its performance.]

Intermediate Result (s)

A key result which must occur in order to achieve a strategic objective.

Strategy (ies)

A set of strategic actions undertaken to achieve the sub-results.

Sub-Result (s)

A set of actions undertaken to achieve an intermediate result.

Performance Indicators

A particular characteristic or dimension used to measure intended changes defined by an organizational unit's results framework.

Results Package -- Strategic Objective(s) + Intermediate Results
[USAID/Cambodia + Local Partners]

Consists of people, funding, authorities, activities, and associated documentation required to achieved a specified intermediate result (s) within an established time frame.

ATTACHMENT 3: Glossory

Activity	An action undertaken either to help achieve a program result or set of results, or to support the functioning of the Agency or one of its operating units.
Agency Goal	A long-term development result in a specific strategic sector to which USAID programs contribute. There are currently five Agency goals.
Agency Objective	A significant development result that USAID contributes to, and which contributes to the achievement of an Agency goal. Several Agency objectives contribute to each goal. Changes in objectives are typically observable only every few years.
Component	Same as results package. (See below.)
Core Team	U.S. Government employees and others who may be authorized to carry out inherently U.S. governmental functions such as procurement actions or obligation of funds.
Customer	Host country people who are end users or beneficiaries of USAID assistance and whose participation is essential to achieving sustainable development results.
Customer Service Plan	A document that presents the expanded team's vision for including customers and partners to achieve its objectives; articulates the actions necessary to engage participation of its customers and partners in planning, implementing and evaluating USAID programs and objectives.
Customer Appraisal	Qualitative research designed to elicit information about the needs, preferences, reactions, and choices of customers.
RGC	Royal Government of Cambodia
Design of Component	Collaborative (USAID/C, RGC, and other private, and CA or NGO partners) development of the recipient's program description and results packages.
Expanded Team	USAID, RGC, partners, other donor agencies, and other interested parties working together and committed to achieve the strategic objective(s).
Implementation	The carrying out of the recipient's program description for the component.
Intermediate Result	A key result which must occur in order to achieve a strategic objective.
Managing for Results	Focusing of individual, team, or organizational efforts on achieving planned results via the results packages.
MOH	Ministry of Health
Output	The product of a specific action, e.g., number of people trained, number of vaccinations administered.
Partner	An organization or individual with whom USAID works cooperatively to achieve mutually agreed upon objectives and to secure customer participation. Partners may include the host-country government; cooperating agencies; contractors; private voluntary organizations or non-governmental agencies; other donor agencies; researchers;

	private businesses; and other interested parties.
Performance Indicator	A particular characteristic or dimension used to measure intended changes defined by an organizational unit's results framework.
Performance Target	The specific and intended result to be achieved within an explicit time frame and against which actual results are compared and assessed. A performance target is to be defined for each performance indicator.
Result	A change in the condition of customers or a change in the host country condition that has a relationship to the customer.
Strategic Framework (or) Results Framework	A narrative statement or graphical representation of the development hypotheses indicating the results and their causal relationships and underlying assumptions necessary for achieving a strategic objective. The framework also establishes an organizing basis for measuring, analyzing, and reporting on the results attendant to achieving the strategic objective.
Results Package	Consists of people, funding, authorities, activities, and associated documentation required to achieve a specified result(s) within an established time frame.
Stakeholder	Individuals or groups that have an interest in and influence USAID activities, programs, and objectives.
Strategic Objective	The most ambitious result (intended measurable change) that a USAID operating unit, along with its partners, can materially affect and for which it is willing to be held responsible. It forms the standard by which the operating unit is willing to be judged in terms of its performance.
Teamwork	The process whereby a group of people work together (often by dividing tasks among members based on relative skills) to reach a common goal, solve a particular problem, or achieve a certain set of results.

ATTACHMENT 4: USAID/CAMBODIA Interim PHN Strategy, 2002 – 2005

(Not attached to this RFA. This is a long document (approx. 60 pgs). If you have not separately received a copy of this document, a copy will be provided to interested applicants under this RFA upon request. Please send email request for this document to: cagordon@usaid.gov . Please note the following document ID when requesting this document: G/RFA/Cambodia Interim HPN Strategy).